84-506

Office-Supreme Court, U.S.
FILED
SEP 28 1984
ALEXANDER L. STEVAS,
CLERK

No.

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1984

METROPOLITAN HOSPITAL,
Petitioner

v.

PROVIDER REIMBURSEMENT REVIEW BOARD OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THOMAS M. TIERNEY, JAMES HOUDEK, JR., AND BETTE A. KRAUS,
Respondents

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Norman Segal
Counsel for Petitioner
Andrew F. Napoli
PINCUS, VERLIN, HAHN, REICH & GOLDSTEIN, P.C.
1710 Spruce Street
Philadelphia, Pa. 19103
(215) 732-3600
Attorneys for Petitioner

PACKARD PRESS / LEGAL DIVISION, 10th & SPRING GARDEN STREETS, PHILA., PA. 19123 (215) 236-2000

QUESTIONS PRESENTED

1. Is the Secretary of Health and Human Services entitled to due deference of a 1977 interpretation of a 1972 Medicare Regulation where the 1972 Medicare Regulation was consistently applied, the 1977 interpretation added additional criteria and was not promulgated pursuant to the Administrative Procedure Act?

2. Is the Secretary of Health and Human Services entitled to due deference of an interpretation of a Medicare Regulation applied retroactively?

3. Is the decision of the Secretary of Health and Human Services supported by substantial evidence, and does the Hospital's maxicare unit qualify as a special care unit under both the 1972 and the 1980 regulations?

TABLE OF CONTENTS

	Page
Opinions below	1, 2
Jurisdiction	2
Statutes and Regulations Involved	2
Statement of the Case	2
Reasons for Granting the Petition	6
Conclusion	17
Appendix A	A-1
Appendix B	A-3
Appendix C	A-10
Appendix D	A-38
Appendix E	A-48
Appendix F	A-50
Appendix G	A-52
Appendix H	A-53
Appendix I	A-54
Appendix J	A-56
Appendix K	A-57
Appendix L	A-59
Appendix M	A-64
Appendix N	A-81
Appendix O	A-106

TABLE OF AUTHORITIES

Cases:

Bowles vs. Seminole Rock & Sand Co., 325 U.S. 410 (1945) 11, 13

Camp vs. Pitts, 411 U.S. 138 (1973) 6

Citizens To Preserve Overton Park vs. Volpe, 401 U.S. 402 (1971) 6

Community Hospital of Indianapolis, Inc. vs. Schweiker, 717 F.2d 372 (7th Cir. 1983) 13

General Electric Co. vs. Gilbert, 429 U.S. 125 (1976) 12

International Board of Teamsters vs. Daniel, 439 U.S. 551 (1979) 12

Morton vs. Ruiz, 415 U.S. 199 (1974) 12

Psychiatric Institute of Washington, D.C., Inc. vs. Schweiker, 669 F.2d 812 (D.C. Cir. 1981).. 14, 15

Rolling Hill Hospital Inc. vs. PRRB, No. 76-1878 (E.D. Pa. 1977) 15, 16

St. John's Hickey Memorial Hospital, Inc. vs. Califano, 559 F.2d 803 (7th Cir. 1979)..... 14

St. Luke's Hospital of Bethlehem, Pa. vs. Schweiker, No. 80-1710 (E.D. Pa. 1981) 14,15

Shea vs. Vialpando, 416 U.S. 251 (1974)..... 12

Skidmore vs. Swift & Co., 323 U.S. 134 (1944). 12, 13

Sun Towers, Inc. vs. Schweiker, 694 F.2d 1036 (5th Cir. 1983)..... 14

United States vs. Pennsylvania Industrial Chemical Corporation, 411 U.S. 655 (1973) 12

White Memorial Medical Center vs. Schweiker, 640 F.2d 1126, (9th Cir. 1981)..... 14

TABLE OF AUTHORITIES—*(Continued)*

Statutes Page

Title V, Section 706 of the Administrative Procedure Act, Judicial Review, 5 U.S.C. §706(2)(E) 6

Title XVIII, §1801 et seq. of the Social Security Act, 42 U.S.C. §1395 eq seq. 2

Section 1816, 42 U.S.C. §1395h 3

Section 1842, 72 U.S.C. §1395u 3

Section 1861, 42 U.S.C. §1395x(v)(1)(A) 2, 4

Section 1871, 42 U.S.C. §1395hh 3

Section 1878, 42 U.S.C. §1395oo 4

Section 1878, 72 U.S.C. §1395oo(f)(1) 4

Regulations

42 C.F.R. Part 405 9

42 C.F.R. Section 405.501 3

42 C.F.R. Section 405.452(d)(7) 4

42 C.F.R. Section 405.452(d)(10)(1972) .. 5, 6, 11, 12, 13, 14, 16, 17

42 C.F.R. Section 405.452(d) (1980) 11, 16

Miscellaneous

Provider Reimbursement Manual, Part 1, §2202.7 (1972) 5, 7

Provider Reimbursement Manual, Part 1, §2202.7 (1977) 5, 7, 11

Provider Reimbursement Review Board Decision #77-D76, CCH Medicare and Medicaid Guide, ¶28,678, p. 10,367 11

No.

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1984

METROPOLITAN HOSPITAL,

Petitioner

v.

PROVIDER REIMBURSEMENT REVIEW BOARD OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THOMAS M. TIERNEY, JAMES HOUDEK, JR., AND BETTE A. KRAUS,

Respondents

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Metropolitan Hospital respectfully prays that a Writ of Certiorari be issued to review the judgment of the United States Court of Appeals for the Third Circuit entered in this proceeding on May 31, 1984.

OPINIONS BELOW

No opinion was rendered by the court of appeals. The decision without opinion is reported at 735 F.2d 1350. (App. A, *infra*, A-1) The opinion of the district court (App. B, *infra*, A-3) is unreported. The report of the magistrate

(App. C, *infra*, A-10) and the decision of the Department of Health and Human Services, Provider Reimbursement Review Board (App. D, *infra*, A-38) are unreported.

JURISDICTION

The judgment of the court of appeals (App. A, *infra*, A-1) was entered on May 31, 1984. A Petition for Rehearing was denied on July 3, 1984 (App. E, *infra*, A-48). The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS INVOLVED

Medicare Act, 42 U.S C. §§1395x(v)(1)(A) (reprinted App. F, *infra*, A-50) and 1395h (App. G, *infra*, A-52) and Regulation 42 C.F.R. 405.452(d)(10) (1972) (App. H., *infra*, A-53) and Regulation 42 C.F.R. 405.452(d) (1980) (App. I, *infra*, A-54).

STATEMENT OF THE CASE

1. This case arises under Part A of the Health Insurance For Aged and Disabled Act (known as the Medicare Act) established in Title XVIII, Section 1801 et seq. of the Social Security Act, 42 U.S.C. §1395 et seq., which authorizes reimbursement to institutional providers of health services for the reasonable and necessary costs of the services provided to Medicare beneficiaries. Reimbursement is based upon the lesser of the provider's reasonable costs in rendering such services or its customary charges with respect to such services. Reasonable costs for the purposes of the Act is defined in Section 1861, 42 U.S.C. §1395x(v)(1)(A) as follows:

> "The reasonable costs of any services shall be the costs actually incurred, excluding therefrom any part of the incurred costs found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations . . .

> such regulations shall (i) take into account both direct and indirect costs of providers of services . . . in order that, under the method of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

Pursuant to this authorization and a Congressional Declaration in Section 1871, 42 U.S.C. Section 1395hh, that "the Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance program under this subchapter," the Secretary of Health and Human Services has promulgated regulations governing the reimbursement of providers under the Act. See 42 C.F.R. §405.501 et seq.

Medicare reimbursement is accomplished through fiscal intermediaries. Sections 1816, 1842, 42 U.S.C. §§1395h and 1395u. The fiscal intermediary in this case is Blue Cross of Greater Philadelphia (Intermediary).

At the close of each fiscal year, providers of services submit cost reports to their respective intermediaries. After an audit of a provider's report, the Intermediary determines the reasonable cost of the reimbursable services which have been provided and the reimbursement due. A distinction is drawn between "routine patient services" and costs attributable to "special care" units. The result is higher payments to providers for patient-beneficiaries treated in special care units reflecting the increased costs attributable to the operation of special care units.

To determine the reasonable costs attributable to a patient treated in a routine care area of the hospital, the average daily costs for routine patient care is calculated by taking the total allowable inpatient costs for routine services and dividing that figure by the total number of inpatient days of care rendered during the accounting period (42 C.F.R. §405.452(d)(7)). The reimbursable costs attributable to patients treated in "special care" units is computed on an average daily costs basis by dividing the total allowable inpatient cost for routine inpatient services by the total number of inpatient days of care rendered in the particular special care unit.

This process is subject to the express Congressional requirement that the costs of rendering services to Medicare patients should not be borne by non-Medicare patients and vice versa. (Section 1861, 42 U.S.C. §1395(x)(v)(1)(A)). This limitation requires Medicare to reimburse a hospital for the share of the total costs representing the services rendered to Medicare patients.

A provider may appeal the intermediary's determination to the Provider Reimbursement Review Board (the Board). Section 1878, 42 U.S.C. §1395oo. The Secretary of Health and Human Services may elect to review that decision and judiciary review is available after the administrative proceedings have been completed. The Statute authorizes a provider to seek judicial review of "any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary. . . ." Section 1878, 42 U.S.C. §1395oo(f)(1).

Metropolitan Hospital (the Hospital) is a provider of health care services under the Medicare Program. In 1945, Metropolitan Hospital opened a cardiac care unit (CCU) and a surgical intensive care unit (ICU). In 1971, the Hospital opened a maxicare unit (MCU). Since 1971, the MCU has been classified along with CCU and ICU as a "special care unit" by the Intermediary. This designation of the MCU as a "special care unit" was pursuant to 42 C.F.R. §405.452(d)(10)(1972) (App. H, *infra*, A-

53), and the Secretary's interpretation of this regulation set forth in Provider Reimbursement Manual,[1] Part 1, Section 2202.7 (1972) (App. J, *infra*, A-56).

In 1977, the Secretary of Health and Human Services issued a revision to the Provider Reimbursement Manual, Part 1, Section 2202.7 (App. K, *infra*, A-57), which was a new interpretation of 42 C.F.R. Section 405.452(d)(10).

Relying on this new interpretation of the regulation, and seven months after the close of the Hospital's 1978 fiscal year, the Intermediary, on February 9, 1979, advised the Hospital that the Hospital's MCU would no longer be considered a "special care unit," but would be considered "routine" for reimbursement purposes. The effect of this declassification on the reimbursement to the Hospital for fiscal year ending June 30, 1978, was $280,141.00. In 1980, the Intermediary retroactively declassified the MCU as routine for fiscal years 1976 and 1977. The effect of this declassification for the year ending 1977 was $173,439.00

Hearings were held before the Board in May of 1981.[2]

---

1. The Provider Reimbursement Manual is a portion of the Health Insurance Manual published by the Health Care Financing Administration. The manual is distributed to intermediaries and instructs them in the application of reimbursement principles.

2. The issues raised by the Hospital before the Board were as follows:

(1) that the Hospital's MCU was a "special care unit" under the applicable regulation — 42. C.F.R. §405.452(d)(10); (2) the Provider Reimbursement Manual (PRM) §2202.7 is inconsistent with Regulation 405.452(d)(10); (3) PRM §2202.7 constitutes a substantive change in Medicare policy and, since it was not enacted pursuant to the rule-making requirements of the Administrative Procedure Act, it is invalid; (4) PRM §2202.7 may not be applied retroactively to the Hospital's Maxicare Unit; (5) the denial of the Maxicare Unit as a "special care unit" would increase the cost of care and Medicare's cost of reimbursement since many Maxicare patients would have to remain in the Hospital's ICU or CCU; and (6) denial of the Hospital's Maxicare Unit as a "special care unit" would increase costs to the other

REASONS FOR GRANTING THE PETITION

1. THE DECISION OF THE THIRD CIRCUIT CONFLICTS WITH DECISIONS OF THE UNITED STATES SUPREME COURT AS TO THE DEGREE OF DEFERENCE TO BE ACCORDED TO AN AGENCY INTERPRETATION

The instant case is a review of the record of an administrative agency hearing as required by statute. Thus, the appropriate standard of review is whether the findings and conclusions of the agency are supported by substantial evidence, 5 U.S.C. §706(2)(D); see *Camp vs. Pitts*, 411 U.S. 138 (1973); *Citizens to Preserve Overton Park vs. Volpe*, 401 U.S. 402 (1971).

The regulation involved in the instant case was passed in 1972. This regulation, which was then 20 C.F.R. §405.452(d)(10), later redesignated as 42 C.F.R. §405.452(d)(10), enumerated six criteria necessary to qualify a unit for special care unit treatment:

> "*Intensive care units, coronary care units, and other special care inpatient hospital units*. To be considered an intensive care unit, coronary care unit, or other special care inpatient unit, [1] the unit must be in a hospital, [2] must be one in which the care required is extraordinary, and [3] on a concentrated, [4] and continuous basis [5] and must be physically identifiable as separate from general patient care areas. [6] There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude post-

---

NOTES *(Continued)*

patients in violation of the Medicare statutes' prohibition against cross-subsidization. The Board and the district court below rejected these arguments; the Third Circuit affirmed.

Concurrent with the passage of that regulation, the Secretary, in the Provider Reimbursement Manual, interpreted this regulation to read as follows:

> "Special Care Units (Provider's Reimbursement Manual, Part 1, §2202.7) (1972).
>
> "To be considered a special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care rendered is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general care areas. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude post-operative recovery rooms, postanesthesia recovery rooms or maternity labor rooms. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment unless the above requirements are met." (App. J., *infra*, A-56).

In 1977, the Secretary of Health and Human Services enacted a new interpretation of the regulation, Provider Reimbursement Manual, Part 1, Section 2202.7 (App. K, *infra*, A-57), the new changes being emphasized, which provided as follows:

> "Special Care Units (Provider Reimbursement Manual, Part 1, §2202.7) (1977).
>
> "A. Requirement to Qualify as an SCU.—To be considered a special care hospital unit, the following requirements must be met.
>
> "1. The unit must be in a hospital.

"2. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. *Extraordinary care incorporates extensive lifesaving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. For this reason, special life-saving equipment should be routinely available in the unit.*

"3. The unit must be physically indentifiable as separate from general care areas *and the unit's nursing personnel must not be integrated with the general care nursing personnel.*

"4. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms or maternity labor rooms. *The unit's staff must be specially trained to serve in such areas.* Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient, hospital units for purposes of apportionment unless the above requirements are met.

. . .

"B. Subintensive Units — Some hospitals have units which provide more intensive care than that provided in the general care areas yet not sufficiently intensive to permit the unit to meet the requirements to qualify as a special care unit under the definition provided in paragraph A above. These units are typically designated as subintensive,

subacute, progressive, or intermediate care units, etc. Such subintensive units are not special care units for purposes of medical reimbursement.

"There may, however, be cases where a unit is not easily identified as a subintensive or special care unit without further study. In such cases, a review of the written policies of the various units will indicate whether a unit is or is not providing care as defined in paragraph A. If the Intermediary determines that such a unit meets the requirements of paragraph A above, then the unit will qualify as a special care unit.

"For example, one indication of whether the unit in question meets the requirements specified in §2202.7A2 is the extent of nursing services provided in the unit. If the hours of nursing service per patient day are less than the hours of nursing services provided in an established special care unit, such as an ICU or CCU in that hospital or in other area hospitals if the hospital has no established special care unit, then the unit in question would generally not qualify as a special care unit. Hospitals should maintain such records as are needed to establish the nursing time in such units. . . ."

(Emphasis supplied).

Then, on May 16, 1979, the Department of Health, Education and Welfare (now Health and Human Services) published its proposed rules for again revising its definition of hospital special care units for reimbursement purposes (42 C.F.R. Part 405) and made the following statements:

"This rule *refines* the definition of hospital special care units and *clarifies* the requirements for their reimbursement under the medicare program. The present special care unit reimbursement regulation

has been erroneously interpreted by some hospitals to apply to units that furnish a level of care that is less than that furnished for intensive care.

"Under the present regulation, units have been designated as special care units, when they are, in fact, intermediate or subintensive care units that render a less intensive level of care. The purpose of this amendment is to *clarify* the intent of the regulation that the term 'special care unit' applies only to those units rendering a level of care that is comparable to intensive care.

. . . .

"Several recent Provider Reimbursement Review Board and Federal court decisions have addressed the issue of whether intermediate or subintensive care units are special care units and have come to *varying conclusions*. These decisions show an existing *lack of uniformity* as to what constitutes a special care unit. In addition, since the regulation was issued, substantial changes have occurred in hospital organization, administration, and financial practices. Increasingly, the inpatient hospital special care unit concept has become an acceptable part of medical care practice. We perceive a definite need to further *refine and clear* away ambiguity as to what a special care unit is to medicare reimbursement purposes. Thus, we propose to amend the regulation." (Emphasis supplied) (App. L, *infra*, A-59, 61-62)

Despite the self-serving declaration in the proposed rule changes that "since the adoption of the special care unit reimbursement policy, we have maintained that only those units rendering a level of care comparable to intensive care should be reimbursed as special care units," the Board had a contrary view. In the first case decided before the Board under the 1977 interpretation, the government argued that the Secretary always maintained a

policy of interpreting the regulation to preclude special care status to units that do not provide care of equal intensity to ICUs of CCUs. The Board found that the June 1977 revision to PRM §2202.7 "is the first time that (the Medicare Bureau) has ennunicated this policy", *PRRB Decision #77-D76*, CCH Medicare and Medicaid Guide, ¶28, 678, p.10, 367, 10, 372. (App. M, *infra*, A-64 at A-76). On August 18, 1980, the Secretary amended 42 C.F.R. §405.452(d)(10). See 42 C.F.R. 405.452 (1980), (App. I, *infra*, A-54).

In the instant case, the decision of the court below, in rejecting special care unit treatment for the MCU, went beyond the plain meaning of the requirements of the published regulation. The administrative agency and the courts below concluded that MCU was not a special care unit because the type of care rendered was not comparable with the Hospital's coronary unit (CCU) and the intensive care unit (ICU). The foundation of this decision is the 1977 "interpretation" of the regulation. (App. K, *infra*, A-57). The district court held that it was required to grant due deference[3] to the decision of the Board because the decision under review involved an agency's interpretation of its own regulation.[4]

The deference given to this interpretation is not warranted, nor do the decisions of this court require such deference. As this Court noted in *Bowles vs. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945):

---

3. It is difficult to give "deference" to an interpretation that the Secretary has characterized as ambiguous, erroneous, and so confused as to require clarification. See (App. L., *infra*, A-59).

4. The Intermediary consistently used the criteria set forth in the 1977 interpretation of the regulation in its position paper to the Board and throughout the hearing before the Board. The district court below also based its Opinion on the criteria as set forth in the 1977 interpretation. This constitutes a retroactive application of the interpretation.

> "A court must . . . look to the administrative construction of the regulations if the meaning of the words used is in doubt."

The 1977 Provider Reimbursement Manual Definition of a special care unit does not fare well under this test. The plain meaning of the words used in 42 C.F.R. §405.452(d)(10) allows for no such doubt here. The regulation itself in no way suggests that special care unit status is limited to intensive care units.

As this Court noted in *International Board of Teamsters vs. Daniel*, 439 U.S. 511, 566, Footnote 20 (1979), deference to an agency's statutory construction is restrained by the court's obligation to honor the clear meaning of a statute. See also *General Electric Co. vs. Gilbert*, 429 U.S. 125, 140-145 (1976); *Shea vs. Vialpando*, 416 U.S. 251 (1974) (the principal that agency construction of its own regulations is entitled to great weight normally applies only where the relevant statutory language is unclear or susceptible of differing interpretations.); *Morton vs. Ruiz*, 415 U.S. 199 (1974). The decision of the Board and the court below was mandated solely by retroactive application of an interpretative rule.

Interpretative rule making, those statements made by an agency to give guidance to its staff and affected parties as to how the agency intends to administer a statute or regulation, is not controlling upon the courts inasmuch as they are not promulgated pursuant to a delegation by Congress of authority to legislate. See *United States vs. Pennsylvania Industrial Chemical Corp.*, 411 U.S. 655 (1973), quoting *Skidmore vs. Swift & Co.*, 323 U.S. 134, 140 (1944). In addition, Justice Jackson, in describing the attitude with which courts regard interpretative rules, commented that:

> "The weight of such a judgment in a particular case will depend upon the thoroughness evidenced in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements,

and all those factors which give it power to persuade, if lacking power to control." *Skidmore vs. Swift & Co.*, 323 U.S. 134, 140 (1944).

The 1977 interpretation and decisions below do not fare well under this test. The supporting reasons are not valid. In addition, the 1977 interpretation conflicts with the earlier interpretation. Further, retroactive application of the interpretation is arbitrary and irrational.

The instant decision below is inconsistent with the Medicare Act and regulation 405.452(d)(10) and is clearly erroneous.

2. THERE IS A CONFLICT AMONG THE COURTS OF APPEALS AS TO THE PROPER INTERPRETATION OF REGULATION 42 C.F.R., §405.452(d)(10) AND THE PROPER DEGREE OF DEFERENCE TO BE ACCORDED THE REGULATORY INTERPRETATION

The Third Circuit's decision in this case conflicts with a prior decision of the Third Circuit and with the decision of the Seventh Circuit. The decision of the court below is based upon a "deferential approach" to be used in reviewing decisions of the Board.

In *Community Hospital of Indianapolis, Inc. vs. Schweiker*, 717 F.2d 372, 375-376 (1983), the Seventh Circuit rejected the precise argument relied upon in this case:

> "The Secretary argues that the Provider Reimbursement Manual definition of a special care unit is entitled to great deference because the Health Care Financing Administration is likely to know more about the underlying intent of 42 C.F.R. §405.452(d)(10) than the courts. Under the circumstances of this cae, however, such deference is not warranted. As the Supreme Court noted in *Bowles vs. Seminole Rock & Sand Co.*, 325 U.S. 410, 65 S.Ct.

1215, 89 L.Ed. 1799 (1945), 'a court must . . . look to the administrative construction of the regulation if the meaning of the words used is in doubt.' Id. at 414, 56 S.Ct. at 1217. *The plain meaning of the words used* in 42 C.F.R. §405.452(d)(10) *allows of no such doubt here. The regulation itself in no way suggests that special care unit status is to be limited to patient care areas where extensive life-saving services are available.*

"Moreover, as this court noted in *St. John's Hickey Memorial Hospital, Inc. vs. Califano,* 599 F.2d 803 (7th Cir. 1979):

> "[T]he degree of deference to be accorded agency action varies with the circumstances, and a careful consideration of the Medicare statute and the manner in which it has been administered reveals that such deference would be particularly inappropriate in this case where we are not setting aside any regulation but only disagreeing with an unofficial interpretation of it.
>
> "Id. at 812. Thus we reject the Secretary's argument that we must defer to the Provider Reimbursement Manual Revision as the dispositive indicator of the regulation's intent." (Emphasis added)

In the instant case, the court below adopted the deference given the Board by the D.C., Fifth and Ninth Circuits. These decisions are based upon due deference to an agency's interpretation of its own regulations. See *White Memorial Medical Center vs. Schweiker,* 640 F.2d 1126, 1129 (9th Cir. 1981); *Psychiatric Institute of Washington, D.C., Inc. vs. Schweiker,* 669 F.2d 812, 813-314 (D.C. Cir. 1981); *Sun Towers, Inc. vs. Schweiker,* 694 F.2d 1036, 1038 (5th Cir. 1983).

The Third Circuit initially rejected the standard above in affirming the decision of the District Court in *St. Luke's*

Hospital of Bethieham, Pa. vs. Schweiker, (E.D. Pa. 1981) C.C.H. Medicare and Medicaid Guide, §31, 501, Aff. D, No. 81-2777 (3rd Cir. June 17, 1982) (App. N, *infra*, A-81). See also *Rolling Hill Hospital, Inc. vs. PRRB*, No. 76-1878 (E.D. Pa. 1977) (C.C.H.) Medicare and Medicaid Guide [1977 Transfer Binder] §288, 745 (App. O, *infra*, A-106). The decisions of this Court do not require the deference granted in this instant case.

This regulation is one of the fundamental regulations governing the medicare program and has a direct and immediate impact upon the program and millions of aged and disabled persons. Accordingly, this case involves not only a question of substantial funds being denied the Hospital, but also a question of substantial importance for the proper operation of the medicare program. The decision below creates a detrimental impact on the very people for whom the medicare program exists.[5]

Finally, the correctness of the decision below, even assuming *arguendo* the propriety of the standard of review employed, is open to serious question. The record shows quite plainly that the findings and conclusions of the Board are not supported by substantial evidence and that the Hospital's MCU is a special care unit within the meaning of the regulation. The magistrate in this case carefully reviewed the record and found that the Hospital's MCU is a special care unit within the regulation, noting that:

> "The Intermediary and defendants in this case contend the characterization that care provided by the MCU was extraordinary, continuous and concentrated. Put quite simply their position on this is-

---

5. In *Psychiatric Institute of Washington, D.C., Inc. vs. Schweiker, supra*, 669 F.2d at 814, the D.C. Circuit expressed deep concern as to the detrimental impact of its decision on the aged. The situation presented in that case is not unique. The Medicare Act does not compel this unpalatable consequence.

sue seems to be that the MCU provides an 'intermediate' level of care falling below that provided in ICU/CCU yet being above that of the routine surg/med floors. Because this care is below that of an intensive care unit, it is not therefore that of a special care unit. This analysis is unavailing in that it deviates from the language of the regulation.

"It has been noted by this court that 'intensive' care is not an element required by 42 C.F.R. §405.452(d)(10) *Rolling Hill Hospital, Inc. vs. PRRB*, E.D. Pa. No. 76-1878 (Nov. 10, 1977), CCH Medicare and Medicaid Guide, ¶28, 745. Further, this Court is not bound to accept the intermediary's or the PRRB's reliance on the interpretative regulation §2202.7 (Provider Reimbursement Manual, Part 1, §2202.7), or the interpretative regulation itself, and it has been held error on the PRRB's part to apply it retroactively. *Rolling Hill Hospital, supra.*

"The Intermediary and the PRRB seemed to be applying extra criteria in determining that Metropolitan Hospital was not a special care unit. We are bound by the language in the regulation as has been stated in *Rolling Hill Hospital, supra.*

> 'Since Congress did not consider the language in the regulation promulgated by the Secretary and here in issue, we do not have the aid of legislative history. The regulation itself is all we have to go by. The six elements, and only those elements, are those which the law and the regulations require in order for the unit to be considered a special care inpatient hospital unit. The regulation does not attempt to describe all the types of special care units that would qualify.'

"It is this court's opinion that the care provided by the MCU was extraordinary, continuous and concentrated. The PRRB's finding to the contrary is not

supported by substantial evidence and misconstrues the regulation applicable to this case. A careful examination of the record in this case reveals that the provider has by a prepondernace of evidence shown that the nursing care provided in the MCU was extraordinary, continuous and concentrated. Accordingly, the PRRB decision on that issue should be reversed as it is not supported by substantial evidence." Report — Recommendation of the Magistrate (App. C, *infra*, A-10 at A-32-33). (Emphasis added).

Recognition of the Hospital's MCU as a hospital special care unit pursuant to 42 C.F.R. §405.452(d)(10) is consistent with the purpose of more accurately allocating Medicare costs and would fulfill the goals of the Act. There are compelling reasons for this court to again state the degree of deference to be accorded administrative agency interpretations and reestablish definitive guidelines for the courts of appeals.

CONCLUSION

For all of these reasons, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

PINCUS, VERLIN, HAHN,
REICH & GOLDSTEIN, P.C.

NORMAN SEGAL, ESQUIRE
Counsel for Petitioner

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
For The Third Circuit

No. 83-1566

METROPOLITAN HOSPITAL,

Appellant

v.

PROVIDER REIMBURSEMENT REVIEW BOARD OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, TIERNEY, Thomas M., HOUDEK, James Jr. and KRAUS, Bette A.

Appeal From the United States District Court
For the Eastern District of Pennsylvania
D.C. Docket No. 82-0796
Before Honorable J. William Ditter, Jr.

Argued May 15, 1984

Before GIBBONS and HUNTER,
Circuit Judges, and STAPLETON*
District Judge

---

*Honorable Walter K. Stapleton, United States District Judge for the District of Delaware, sitting by designation

JUDGMENT ORDER

After consideration of all contentions raised by appellant, it is

ADJUDGED and ORDERED that the judgment of the district court be and is hereby affirmed.

Costs taxed against appellant.

By the Court,

/s/ JAMES HUNTER

Circuit Judge

Attest:

/s/ SALLY MRVOS

Clerk

Dated: May 31, 1984

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

METROPOLITAN HOSPITAL *Plaintiff*	:	CIVIL ACTION No. 82-0796
v.	:	
PROVIDER REIMBURSEMENT REVIEW BOARD, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THOMAS M. TIERNEY, JAMES HOUDEK, JR. AND BETTE A. DRAUS *Defendants*	:	

MEMORANDUM AND ORDER

DITTER, J. July 8, 1983

The United States Magistrate has submitted a comprehensive report and recommendation in this action brought pursuant to 42 U.S.C. §1395oo(f) to review a decision of the Provider Reimbursement Review Board (PRRB). In its decision, the PRRB determined that plaintiff's maxicare unit (MCU) did not qualify as a "special care unit" under 42 C.F.R. §405.452(d)(10) (1978) and that the plaintiff was not entitled to reimbursement for its interest expense for certain money borrowed because the PRRB found that this money was used to fund depreciation. This decision became the final decision of the Secretary of Health and Human Services on February 10, 1982, when the Secretary, through the Deputy Administrator of the Health Care Financing Administration, declined to reverse, affirm, or modify the PRRB's decision. 42 U.S.C. §1395oo(f)(1) (1976). Presently before me are cross motions for summary judgment. The Magistrate has recommended that I reverse the PRRB's decision as to the special care unit issue and affirm it as to the interest expense reimburse-

ment issue. After a careful review of the extensive record and pleadings, I have reached a partially different conclusion. Because there is substantial evidence to support the ruling of the PRRB on both issues, I will affirm its decision and grant the Secretary's motion for summary judgment.

My review of this decision is to determine, pursuant to 5 U.S.C. §706, whether the agency's findings are supported by substantial evidence. *White Memorial Medical Center v. Schweiker*, 640 F. 2d 1126, 1129 (9th Cir. 1981); *Rolling Hills Hospital v. PRRB*, [1977 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶28,745 (E.D. Pa. Nov. 10, 1977). Because of the nature of the issues involved, courts have recognized that a deferential approach should be used in reviewing decisions of the PRRB. As the District of Columbia Circuit has stated:

> [W]here the decision under review involves an agency's interpretation of its own regulations, forming part of a complex regulatory scheme which the agency is charged with administering, the arguments for deference to administrative expertise are at their strongest. A reviewing court may not set aside the agency's interpretation merely because another interpretation was possible and seems better, so long as the agency's interpretation is within the range of reasonable meanings that the words of the regulations admit.

Psychiatric Institute of Washington, D.C. v. Schweiker, 669 F. 2d 812, 813-14 (D.C. Cir. 1981). *Accord Sun Towers, Inc. v. Schweiker*, 694 F. 2d 1036 (5th Cir. 1983); *White Memorial Medical Center v. Schweiker*, supra.

In order to qualify as a special care unit, the facility must satisfy each of the following six criteria:

1. The unit must be in a hospital;

2. The patient care in the unit must be extraordinary;

3. The care in the unit must be continuous;

4. The care in the unit must be concentrated;

5. The unit must be physically identifiable as separate from general patient care areas; and

6. The unit must have specific written policies. 42 C.F.R. §405.452(d)(10) (1978). The issues presented here are whether the MCU had specific written policies and whether the care provided in the unit was extraordinary, concentrated, and continuous. The PRRB determined that the MCU failed to satisfy these criteria and therefore did not qualify as a special care unit.

The Magistrate has thoroughly detailed the evidence presented to the PRRB and I adopt his summarization for the purpose of this memorandum. With regard to the first issue, I agree with the Magistrate that the PRRB's finding that specific written policies did not exist for this unit is not supported by substantial evidence. Although it is uncontroverted that specific written policies for the MCU existed in various committees' minutes and memoranda (R. 72-84, 113-115, 129-133, 185-187), the PRRB concluded that this criterion had not been satisfied because these policies had not been placed in a manual during the period in question. This rationale is faulty because it imposes an additional requirement that is not called for by the statutory language. The statute speaks only in terms of specific written policies, and does not mandate that the policies be consolidated into a separate manual.

The PRRB also decided that the MCU did not render service that was extraordinary, concentrated, and continuous. Contrary to the magistrate's recommendation, I conclude that this finding is supported by substantial

evidence. The PRRB reached its conclusion by comparing the care provided in the MCU with that provided in the hospital's other two special care units, the Coronary Care Unit (CCU) and the Intensive Care Unit (ICU). Plaintiff, on the other hand, asserts that this comparison is impermissible (Plaintiff's Memorandum in Support of Motion for Summary Judgment at 23), and instead has based its analysis upon a comparison of the MCU with the routine care units.[1] The approach adopted by the PRRB, however, is an acceptable comparison under the regulations. *See Sun Towers, Inc. v. Schweiker*, 694 F.2d 1036, 1038 (5th Cir. 1983); *Psychiatric Institute of Washington, D.C. v. Schweiker*, 669 F.2d 812, 814 (D.C. Cir. 1981).[2] Considering the record as a whole, there is substantial evidence that the level of care provided in the MCU was less extraordinary, concentrated, and continuous than the care in the CCU and ICU facilities.

The evidence in support of the PRRB's decision includes:

1. The nursing hours per patient day in the MCU for 1978 were 12.66 as compared to 24.01 and 27.97 in the CCU and ICU, respectively (R. 688);

---

1. Plaintiff relies heavily upon the facts that the education and training required of MCU nurses is above that required of routine care nurses, that the nursing hours per patient day and costs per patient day in the MCU are in excess of those in the routine care areas, and that certain medical procedures and devices are available in the MCU which are unavailable in the routine care areas in support of its position that the MCU qualifies as a special care unit.

2. This test is not inconsistent with *Saint Luke's Hospital v. Schweiker*, [1981-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶31,501 (E.D. Pa. 1981), *aff'd mem.*, No. 81-2777 (3d Cir. June 17, 1982), where Judge Cahn rejected the Secretary's contention that the issue should be whether a particular unit was "equal to" an ICU or CCU. I also reject this "equality" test as being unsupported by the statutory language.

2. The cost per patient day in the MCU for 1978 was $207. as compared to $378. and $406. in the CCU and ICU, respectively (R. 687).

3. There was a marked disparity in the electronic monitoring devices available in the MCU and the CCU/ICU. In 1978, the MCU had only two telemetry units, which had to be monitored by a coronary care nurse, rather than a maxicare nurse. (Hearing of May 14, 1981 at 205) (hereinafter H. 14). In contrast, most, if not all, ICU patients were constantly monitored (H. 14 at 152-153).[3]

4. The physical layout of the MCU was dissimilar to that of the ICU/CCU. The MCU has 19 beds in semi-private rooms which are virtually identical to the routine care units. The heads of the beds are not visible from the nurses' station. In contrast, the glass walls of the CCU permit the patients to be visually monitored from the nurses' station at all times. (H. 14 at 87,207).

5. Approximately 39 per cent of MCU patients were transferred there from the ICU/CCU areas, once their conditions had stabilized sufficiently to permit their transfer. (H. 14 at 58, 59, 198).

6. Unlike the ICU/CCU areas, the MCU rooms had televisions and telephones available (H. 14 at 117) and, in general, had more liberal visiting privileges. (Hearing of May 15, 1981 at 20).

---

3. The significance of this disparity was shown at the hearing. When questioned about what would happen in the event an unmonitored and unobserved MCU patient suffered a cardiac arrest, Fran Shuta, the plaintiff's Critical Care Coordinator, responded, "The same thing that would happen to them in any other area. . . . Someone would obviously find the patient without a pulse or without respiration and . . . hopefully would institute CPR and call code." (H. 14 at 152)

7. Patients' vital signs in the MCU were taken every four hours, while those in ICU/CCU were taken every two hours. (H. 14 at 207).

Although the plaintiff's arguments have some merit, *see* note 1 *supra*, they fall short of the standard necessary to disturb the Secretary's decision. Substantial evidence exists in the record to support a finding that the MCU furnishes a level of care that may be reasonably characterized as lower than that provided in the ICU/CCU areas.

The second issue involves whether the PRRB properly decided that the plaintiff was not entitled to reimbursement for interest expense on borrowed funds because of the PRRB's determination that the money was borrowed to fund depreciation. After a thorough review of the record and the pleadings on this issue, I fully agree with the Magistrate that the PRRB's decision is supported by substantial evidence. Especially damaging to the plaintiff's contention that the money borrowed was used for patient care is the fact that plaintiff's depreciation account increased significantly in fiscal year 1978 while its capital account carried a substantial deficiency. I therefore adopt and approve the Magistrate's report and recommendation on this issue and affirm the decision of the PRRB.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

METROPOLITAN HOSPITAL *Plaintiff*	:	CIVIL ACTION No. 82-0796
v.	:	
PROVIDER REIMBURSEMENT REVIEW BOARD, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THOMAS M. TIERNEY, JAMES HOUDEK, JR. AND BETTE A. DRAUS *Defendants*	:	

ORDER

AND NOW, this 8th day of July, 1983, for the reasons expressed in the foregoing memorandum, it is hereby ordered that summary judgment is granted in favor of the defendants.

BY THE COURT

/s/ J. WILLIAM DITTER, JR.

J.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

METROPOLITAN HOSPITAL	:	CIVIL ACTION
v.	:	
PROVIDER REIMBURSEMENT REVIEW BOARD OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THOMAS M. TIERNEY, JAMES HOUDEK, JR. BETTE A. KRAUS	:	NO. 82-0796

REPORT — RECOMMENDATION

EDWIN E. NAYTHONS OCTOBER 20, 1982
UNITED STATES MAGISTRATE

This is an action brought by the plaintiff Metropolitan Hospital as a Medicare provider, pursuant to §1878(f) of the Social Security Act, as amended, 42 U.S.C. §1395oo(f) and 5 U.S.C. §701 *et seq.* to review the final decision of the Provider Reimbursement Review Board ("PRRB") denying plaintiff the right to treat its Maxi-Care Unit as a special care inpatient hospital unit for purposes of Medicare reimbursement. The Court presently has before it cross-motions for summary judgment as well as a motion to dismiss filed by the defendant.

BACKGROUND

The Health Insurance for the Aged Act (otherwise known as the "Medicare Act"), 42 U.S.C. §1395-1395pp(1976), provides by its terms for two distinct classifications of federal medical care support for the aged and certain disabled persons. Under Part A of the Act, hospitals, nursing homes, and similar-type facilities

classified as "providers" are reimbursed by the Secretary of Health and Human Services through designated "fiscal intermediaries" for the "reasonable cost" incurred by such providers for inpatient hospital services and certain other services rendered following such inpatient hospital care. 42 U.S.C. §§1395c-1395i-2 (1976). Part A Medicare beneficiaries generally receive hospital and related care services at no charge; the providers of the services then receive direct reimbursement from the Government through the fiscal intermediaries. Part B of the Act establishes a voluntary medical insurance program which pays for various health services not covered by Part A of the Act, such as physician services and certain laboratory fees. 42 U.S.C. §61395-j-1395w (1976). Part B is partially financed by premiums paid by its enrollee members. 42 U.S.C. §1395s (1976).

Reimbursement of providers differs as to Parts A and B. Under Part B, reimbursement is premised on the "reasonable charges" of the individual or entity providing the services, although in some instances a provider may receive Part B reimbursement based on 80% of its reasonable costs. 42 U.S.C. §13951 (1976). Part A reimbursement, on the other hand, is based upon the lesser of the provider's "reasonable cost" in rendering such services or its "customary charges" with respect to such services. 42 U.S.C. §1395f(b) (1976). "Reasonable cost" for purposes of the Act is defined in 42 U.S.C. §1395x(v)(1)(A) (1976) as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations. . . . Such regulations shall (i) take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered ser-

> vices to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

Pursuant to this authorization and the Congressional declaration in 42 U.S.C. §1395hh (1976) that "[t]he Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance program under this subchapter", the Secretary of Health and Human Services (formerly Secretary of Health, Education, and Welfare) has promulgated regulations governing the reimbursement of providers under the Act. *See* 42 C.F.R. §6405.401-405.488 (1977).

Medicare reimbursement is most often accomplished through fiscal intermediaries. *See* 42 U.S.C. §§1395h, 1395u (1976). The fiscal intermediary in this case is the Blue Cross of Greater Philadelphia, a subcontractor for the Blue Cross Association, hereinafter referred to as intermediary.

At the close of each fiscal year, providers of services submit "cost reports" to their respective intermediaries. 42 C.F.R. §405.406(b). After an audit of a provider's report, the intermediary determines the "reasonable cost" of the reimbursable services which have been provided, and accordingly the reimbursement due. 42 C.F.R. §405.454(f). A distinction is drawn between "routine patient services" and costs attributable to so-called "special care" units.

To determine the reimbursable costs attributable to patient-beneficiaries treated in a non-special care unit of the hospital, the average daily cost for routine patient

care is calculated by taking the total allowable inpatient cost for routine services and dividing that figure by the total number of inpatient days of care rendered during the accounting period. 42 C.F.R. 405.452(d)(7). The reimbursable costs attributable to patient-beneficiaries in "special care" units are computed on an average daily cost basis by dividing the total allowable inpatient cost for routine services by the total number of inpatient days of care rendered only in the particular special care unit under consideration. 42 C.F.R. §405.452(d)(8). The result is higher payments to providers for patient-beneficiaries treated in special care units reflecting the increased costs attributable to the operation of special care units.

When a provider disagrees with the intermediary's reimbursable costs determination, it may obtain a hearing before the Provider Reimbursement Review Board (hereinafter "PRRB"), pursuant to 42 U.S.C. §1395oo (1976).[1] *See also*, 42 C.F.R. §405.1835. PRRB, basing its

---

1. 42 U.S.C. §1395oo(a) (1976) states:

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section, if—

(1) such provider—

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where

decision "upon the record made at such hearing" is authorized to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. §1395oo(d) (1976). Decisions of the PRRB constitute the final decision of the Secretary of Health and Human Services unless within 60 days of the providers receiving notice of the PRRB's decision, the Secretary on his own motion, reverses, affirms, or modifies the PRRB's decision. 42 U.S.C. §1395oo(f)(1) (1976). The Secretary has delegated his responsibility for administering the Act to the Administrator of the Health Care Financing Administration.

FACTS

Plaintiff, Metropolitan Hospital, is a 215 bed short term, non-profit acute care hospital which has been in existence since 1945 organized and existing under the laws of the Commonwealth of Pennsylvania. Its principal place of business is located at 201 N. Eighth Street, Philadelphia, Pennsylvania, where it has been located since 1971. The hospital is a provider of health care services under the Medicare Program and as part of its services allocates 19 beds for its Maxi-care Unit ("MCU"), 5 beds for an Intensive Care Unit ("ICU"),

NOTES *(Continued)*

such cost report did not so comply and such supplementary cost report did so comply.

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A) or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

and 5 beds for a Coronary Care Unit ("CCU"). The defendants are the PRRB and the Chairman and other members of the PRRB, each being sued in his official capacity.

When the hospital opened in 1945, the CCU and ICU were established. In 1971, when the hospital moved to its present location, the hospital opened its Maxi-Care Unit. Pursuant to regulations and requirements of the Medicare program, the hospital filed a cost report for the fiscal year ending June 30, 1978 with its intermediary, the Blue Cross of Greater Philadelphia. In its cost report, the hospital treated its Maxi-Care Unit as a special care unit pursuant to 20 C.F.R. 405, Regulations No. 5, Subpart D. Principles of Reimbursement, §405.452(d)(10),[2] and completed a separate average per diem cost for the MCU. On February 9, 1979, the intermediary advised the hospital that the MCU, which along with the CCU and ICU had been classified by the intermediary since 1971 as a "special care unit" for fiscal years up to and ending 1977, would no longer be considered a special care unit but rather would be considered as providing "routine" services for reimbursement purposes.[3]

---

2. 42 C.F.R. §405.452(d)(10) provides for special care units as follows:

"Intensive care units, coronary care units, and other special care inpatient hospital unit. To be considered an intensive care unit, coronary care unit, or other special care inpatient unit, the unit must be in a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general patient areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units but exclude post operative recovery rooms, post-anesthesia recovery rooms or maternity labor rooms."

3. The intermediary based its declassification of the MCU on Regulation Provider Reimbursement Manual (PRM)-1 §2202.7 (HIM-15 §2202.7) which states:

On November 26, 1979, the intermediary filed its Notice of Program Reimbursement ("NPR") which reclassified the hospital's MCU from "special" to routine". The effect of the reclassification on the reimbursement for the fiscal year ending June 30, 1978, is a figure of $280,141.00. The NPR of November 26, 1979 also disallowed requested interest expense deductions for fiscal year ending 1978 on monies borrowed by the hospital. The Intermediary's rationale for this disallowance, which represented an amount of $52,054.00, was that the money borrowed was borrowed to fund depreciation in violation of 42. C.F.R. §405.419.

On February 13, 1980, the intermediary advised the hospital that the cost reports for the years ending 1976 and 1977 would be reopened "to combine the Maxicare Unit with routine service." (Tr. 0859). On February 28, 1980, the intermediary filed a revised NPR for the fiscal years 1976 and 1977 in which the MCU was reclassified to routine care. (Tr. 0860-0861). The effect of the re-

---

NOTES *(Continued)*

Special Care Unit/Intensive Care Type Units (Prov. Reimb. Man., Part 1, §2202.7)

1. Special Care Units for Cost Reporting Periods Beginning Prior to October 1, 1980

A. Requirements to Qualify as an SCU — To be considered a special care inpatient hospital unit, the following requirements must be met:

1. The unit must be in a hospital.

2. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive life-saving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. For this reason, special life-saving equipment should be routinely available in the unit.

3. The unit must be physically identifiable as separate from general care areas and the unit's nursing personnel must not be integrated with the general care nursing personnel.

classification for the year ending 1977 was $173,439.00. The reclassification by the intermediary was based upon its conclusion that the following requirements of 42 C.F.R. §405.452(d)(10) had not been met:

(1) the unit must have specific written policies, and

(2) the unit must provide care which is extraordinary and do so on a concentrated and continuous basis.

Plaintiff requested a hearing before the PRRB which was held on May 14 and 15, 1981 in Linthicum Maryland. On December 21, 1981, the PRRB issued a Hearing Decision, No. 82-026, denying the hospital the right to treat its Maxi-Care Unit as a special care unit. (Tr.

---

4. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms, or maternity labor rooms. The unit's staff must be specially trained to serve in such areas. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment unless the above requirements are met.

NOTE: If a neonatal unit qualifies as an SCU, the days are considered SCU days rather than nursery days (see Part II, Chapter 3, §304.2 [¶9304B], lines 4, 5, 6, paragraph 5). A regular well-baby nursery may not be considered an SCU.

See §2217 [¶6250] where a hospital places general care patients temporarily in special care units because all available general care beds are occupied.

B. Subintensive Units.—Some hospitals have units which provide more intensive care than that provided in the general care areas yet not sufficiently intensive to permit the unit to meet the requirements to qualify as a special care unit under the definition provided in paragraph A above. These units are typically designated as subintensive, subacute, progressive, or intermediate care units, etc. Such subintensive units are not special care units for purposes of Medicare reimbursement.

0014-0021.) The PRRB decision which reiterated the intermediary's, was based upon the intermediary's findings that the hospital did not have specific written policies nor did it provide extraordinary, concentrated and continuous care, for purposes of 42 C.F.R. §405.452(d)(10) (Tr. 0020).

As to the issue of specific written policies, the PRRB noted that "it appears that no specific manual or instructions existed *during* the period in question; at least documentation was not made available to the Intermediary sufficient to satisfy this prerequisite." [Emphasis in original.] (Tr. 0020.) The PRRB stated that:

> It is noted that the Provider submitted documentation by post-hearing procedure *(Provider's Post-Hearing Brief,* attachment 2) which appears to affirm the status of the unit in question, i.e., that it is an "intermediate unit." (Tr. 0020.)

As to the second issue of whether the ICU provided extraordinary, concentrated and continuous care, the PRRB noted a comparison made by the intermediary of the hospital's MCU and CCU/ICU and found it "difficult

---

NOTES *(Continued)*

C. Special Care Unit Cost Center.—For purposes of reimbursement, hospitals utilizing the departmental method of cost apportionment must determine the average cost per diem for each special care unit. For example:

A hospital has two physically separate SCU's, an ICU and CCU, serviced by two nursing stations. For settlement purposes, the ICU and CCU would be considered as two distinct SCU's, thus requiring two cost centers.

Where a hospital utilizing the departmental method has a physically combined SCU, e.g., ICU-CCU, the combined ICU-CCU would be considered one SCU. For example:

A hospital gives both ICU and CCU care in one area serviced by one nursing station. For settlement purposes, the combination of the ICU and CCU would be considered as a single SCU, thus requiring a single cost center.

Hospitals utilizing the combination method of cost apportionment must combine all SCU's into one cost center.

to surmount". (Tr. 0020.) The PRRB summarized the intermediary's comparison of the MCU and CCU/ICU as follows:

> 1. The nursing hours per patient day comparisons clearly demonstrate that the staffing levels in the MCU were considerably less than that in the CCU/ICU. Indeed, in terms of nursing care, the MCU is more comparable to the routine area.
>
> 2. A comparison of the Provider's charge structure denoted that the MCU charges were only 13% higher than routine areas.
>
> 3. A review of the admissions policy denoted that 39% of the patients admitted to the MCU were from the ICU/CCU. This established that a significant number of the patients were transferred from a more intensive level of care to a lower level of care.
>
> 4. The visitor's policy denoted that the MCU was similar to routine.
>
> (Tr. 0020.)

On February 10, 1982, the Deputy Administrator for Health Care Financing Administration declined to reverse, affirm, or modify the decision of the PRRB. (Tr. 1-3.) The hospital brings this action asserting that the decision of the PRRB is not supported by substantial evidence. The hospital seeks a declaratory judgment stating that the Maxi-Care Unit is a special care unit for reimbursement cost purposes and also seeks an order of reimbursement in the amount of $52,054.00, a figure the plaintiff alleges represents requested interest expense deductions for fiscal year ending 1978 on monies borrowed by the hospital. The defendants assert that the PRRB's decision is supported by substantial evidence and seeks summary judgment on that basis.

STANDARD OF REVIEW

Judicial review may be obtained of the PRRB's decision or of the Secretary's decision, whichever is final, 42 U.S.C. §1395oo(f)(1), in a federal district court pursuant to the applicable provisions under Chapter 7 of Title 5. Section 706 of Title 5 defines the scope of review of agency action as follows:

> §706 Scope of review.
>
> To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—
>
> (1) compel agency action unlawfully withheld or unreasonably delayed; and
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be—
>
> (A) arbitrary, capricious an abuse of discretion, or otherwise not in accordance with law;
>
> (B) contrary to constitutional right, power, privilege, or immunity;
>
> (C) in excess of statutory jurisdiction authority, or limitations, or short of statutory right;
>
> (D) without observance of procedure required by law;
>
> (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
>
> (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court. In making the foregoing deter-

> minations, the court shall review the whole record or those parts of it cited by a party and due account shall be taken of the rule of prejudicial error.

Because the present case is being reviewed on the record of an administrative agency hearing provided and required by statute, the appropriate standard of review is a determination of whether the findings of the agency are supported by substantial evidence. *Camp v. Pitts*, 411 U.S. 138 (1973); *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971). Substantial evidence is defined as such relevant evidence which a reasonable mind might accept as sufficient to support a conclusion; it consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance. *Dobrowolsky v. Califano*, 606 F.2d 403, 406 (3rd Cir. 1979). The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's decision from being supported by substantial evidence. *Consolo v. Federal Maritime Commission*, 383 U.S. 607, at 620 (1966). This standard is intended to free "the reviewing courts of the time-consuming and difficult task of weighing the evidence" to give "proper respect to the expertise of the administrative tribunal" and to help "promote the uniform application of the statute." *Consolo, supra.* at 520.

ISSUES

The issues before this Court center on the regulation contained at 42 C.F.R. §405.452(d)(10) which requires six separate criteria necessary for classification as a special care unit. Those six criteria are:

1. The unit must be in a hospital
2. The patient care in the unit must be extraordinary

3. The care in the unit must be concentrated
4. The care in the unit must be continuous
5. The unit must be physically identifiable as separate from general patient care areas; and
6. The unit must have specific written policies.

The parties have stipulated that the hospital's MCU is in a hospital and is physically identifiable as separate from the general routine areas of the hospital. This Court must therefore decide whether the PRRB's decision that the hospital's MCU cannot be classified as a special care unit for fiscal year ending 1977 because the MCU had no specific written policies and because the care in the MCU was not extraordinary, concentrated and continuous, is supported by substantial evidence.

In addition, we must ascertain if the PRRB's decision that moneys borrowed during fiscal year 1978 were used to fund depreciation rather than for operating expenses, is supported by substantial evidence. We turn to the first issue.

PROVIDER'S WITNESSES

At the hearing before the PRRB, the provider produced four witnesses who testified to the issues concerning whether the MCU did in fact have specific written policies and also whether the care the MCU provided was in fact "extraordinary, continuous, and concentrated."

Wayne Byerly, the Executive Director of Metropolitan Hospital since 1974, stated that the hospital is a general acute care hospital. (Trans. 5-14-81 p. 23), and that the MCU has been paid by the intermediary as a special care unit since 1971. (Trans. 5-14-81, p. 24.) Mr. Byerly testified that patients in ICU, CCU, and MCU are not continuously monitored by telemetry or had core monitoring (electronic devices), although the capability

for doing so exists for all beds in the CCU and MCU (Trans. 5-14-81, pp. 33-34).

Dr. Albert Bonier, Medical Director at Metropolitan Hospital since July 1, 1980 testified that he was a member of the Medical Executive Committee which formed in 1971. (Trans. 5-14-81, p. 56). Dr. Bonier testified that the MCU was established in response to the "state of the art in the practice of medicine in 1971" to provide extraordinary, concentrated attention to patients as opposed to routine care. (Trans. 5-14-81, p. 57). He stated that the Medical Executive Committee felt that in order to provide better patient care there was a need for a special care unit (i.e. MCU) adjacent to CCU and ICU for purposes of transfer when necessary for whatever reason or for direct admission to Max care in those instances when the unit was filled or in those instances in which the attending physician felt that extraordinary care could be rendered in the special care unit. (Trans. 5-14-81, p. 61). Dr. Bonier testified as to the types of patients who are admitted to the MCU: trauma cases; severe trauma cases; patients who have undergone severe extreme major surgical procedures, vascular procedures, or complicated major abdominal procedures; patients with trauma who have undergone major abdominal surgery; and patients who have pulmonary complications. (Trans. 5-14-81, p. 60). The admission of patients to the MCU is left primarily to the attending physician. (Trans. 5-14-81, pp. 42-43).

Dr. Bonier testified that the MCU has had specific written policies and procedures which have been in existence since 1973 and which were contained in the minutes of the critical care committee and in the Nursing Guide and the nursing policies. (Trans. 5-14-81, p. 65). Dr. Bonier made reference to two specific written policies; one, from the minutes of the Critical Care Committee regarding physicians' decisions to transfer patients out of the MCU, and the second from the Medical Executive Committee rules and regulations re-

garding closing of the emergency room when the ICU and critical care areas are full. (Trans. 5-14-81, pp. 46, 47). Additionally, Dr. Bonier testified that written policies and procedures for treatment, admission, and transfer of MCU patients have been in effect since 12/5/73 as contained in a memo of that date from the minutes of the medical executive committee. (Trans. 5-14-81, pp. 68-69).

Dr. Bonier testified that the MCU provides extraordinary and concentrated care as well as continuous care. (Trans. 5-14-81, p. 83). He also testified that the level of care is not below that of established special care units. (Trans. 5-14-81, p. 58). The level of care in the MCU is substantially the same as that in ICU/CCU, primarily on the basis of nursing care. Additionally, there is monitoring equipment in the CCU and MCU "to a degree." (Trans. 5-14-81, p. 62). Dr. Bonier testified that nurses in maxicare are categorized as critical care nurses and they have the same equivalent training as nurses in CCU and ICU. The MCU nurses, can, if need be, rotate through CCU and ICU because they do have those capabilities. They are educationally updated so that they can handle critical care patients; their ratio is one-to-two patients. (Trans. 5-14-81, p. 90).

Jacqueline Harris, Assistant Administrator of Nursing at Metropolitan Hospital testified that specific written policies for the Maxicare Unit have existed at least since 1973 and have been greatly developed, clarified, and expanded upon since that time. (Trans. 5-14-81, pp. 99-100). "The Maximum Care Unit has very specifically designed policies for aspects of nursing care which we would not perform in other units — including IV medication pushes which corrolated with the patient's overall disease condition." (Trans. 5-14-81, p. 98). Additionally, Ms. Harris testified that the Nursing Policy book which contains information on every unit of the hospital and every nursing unit contained policies for the MCU. (Trans. 5-14-81, p. 101). Additionally, the current

manual which was presented at the PRRB hearing was put together by the Nursing Department which combed the various sources where the policies existed and collated those into a one book manual form. (Trans. 5-14-81, pp. 104-105).

Ms. Harris stated that she does not consider the MCU to provide an intermediary level of care but found it similar to the care provided in ICU/CCU in that there is a one-to-two or-three nurse/patient ratio and 24 hour/day direct on-going monitoring. Staffing in ICU is 1/1. (Trans. 5-14-81, pp. 108-109). She testified that televisions, telephones and more liberal visiting hours are in existence in the MCU and not the ICU or CCU because of the variance in size in those areas — the MCU is a 19 bed unit and the ICU and CCU are only 5 bed units which size does not allow these or visiting hours. (Trans. 5-14-81, pp. 117-118). Specialized life saving equipment is available to any of the critical care units and there are respirator patients in all three units. (Trans. 5-14-81, p. 118). As to nursing care provided in the MCU, Ms. Harris testified that the MCU nursing staff decreases at night and on week-ends due to the fact that nurses are oriented during the day and there is no head nurse at night. (Trans. 5-14-81, p. 119). MCU is the only unit with an assistant head nurse on each shift. There is a difference in pay for nurses for all three units. (Trans. 5-14-81, pp. 121, 123). Lastly, an MCU nurse spends any where from two to three hours per shift at various intervals inside a patient's room. (Trans. 5-14-81, p. 126).

Fran Shuta, the Critical Care Coordinator at Metropolitan Hospital since November, 1979 testified that she is the supervisor for the ICU, CCU, and MCU and is responsible for the ongoing education and continuing assessment of the quality of care the nurses provide. (Trans. 5-14-81, pp. 143-144). Ms. Shuta stated that she considers the nursing care in the MCU to be extraordinary, continuous and concentrated. (Trans. 5-14-81, p.

153). She testified that nurses in all three critical care units have the exact same educational requirements and must be trained in the following: cardiac life support, advance life support, basic arhythmia course, and critical care course. (Trans. 5-14-81, p. 145). "Virtually all the same procedures that are done in CCU or ICU are done on Maxicare . . . (and) are not done on General Floors. Specifically, those being peritonial dialysis, ventillator patients (which are never on med/surg floors), pacemaker — fresh out pacemaker insertions, any hemodynamic monitoring, cardiac monitoring, and IV drugs." (Trans. 5-14-81, p.146). Ms. Shuta stated that the MCU has a single channel 12 — lead EKG machine, a portable defibrillator monitor, crash cart equipped with drugs, hardwire monitoring, telemetry monitoring, non-invasive blood pressure machines, all of which are not generally available on routine floors. (Trans. 5-14-81, p. 148).

Dr. William Nickey, head of the Metropolitan Hospital Section of Nephrology and Hypertension testified that the MCU patients receive extraordinary, concentrated and continuous care and that patient needs in MCU and CCU/ICU are the same. (Trans. 5-14-81, pp. 164, 170, 183). Also, Dr. Nickey stated that the ICU and MCU are the same except that the ICU does more routine invasive hemodynamic monitoring. (Trans. 5-14-81, pp. 170-171).

The hospital prepared an analysis of nursing hours per patient day and cost per patient day for submission to the PRRB which was admitted by the PRRB as part of the hospital's case (Trans. 0868-0869). The nursing hours per patient day in the MCU was 12.66 as opposed to an average of 6.55 for routine care. The CCU nursing hours per patient day was 24.01 and the ICU was 27.97.

With respect to the cost of the unit per patient day, the MCU for 1977 was $176.63 as opposed to $114.68 for routine service. $273.05 for CCU and $327.29 for ICU. For 1978, the MCU cost was $206.92 per day, the

routine service was $124.22, the CCU was $378.18 and the ICU was $406.39. (Trans. 0868-0869).

INTERMEDIARY'S WITNESSES

The intermediary produced two witnesses who testified to the issues of specific written policies and extraordinary, concentrated and continuous care in the MCU. Dr. Eleanor Hudson, consultant to the intermediary since 1975 and a Board Certified Anaesthesiologist (Trans. 5-14-81, p. 188), analyzed 14 cases which had been in the MCU in May, 1978 by looking at doctors' orders, and nurses' notes for patterns of admission, discharge, and transfer and noted that all the cases admitted to the ICU or CCU were subsequently transferred to MCU before being transferred "out to the floor", thus indicating to her that this level of care in the MCU differed from that in the ICU. (Trans. 5-14-81, pp. 197-198). She characterized the level of care as being similar to that of an Intermediate Care Unit and stated that the admissions policy criteria indicated to her that the MCU was treating a group of patients who are not acutely ill. (Trans. 5-14-81, p. 199, 200). Additionally, her review of these fourteen cases led her to the conclusion that most of the patients could have been provided care on the general floor. (Trans. 5-14-81, p. 202).

Dr. Hudson stated that the MCU's care was not extraordinary, concentrated, and continuous compared to the ICU and CCU and because of this is not a special care unit. (Trans. 5-14-81, p. 217). She noted several differences between the three units:

> The Maxicare Unit has 19 beds in semi-private rooms which are the same as the rooms in every other Medical/Surgical floor of the hospital. The patients cannot be seen from the nursing station. The head of the bed is at the other end of the room from the doors so that they are not visible.

> In the Coronary Care Unit the patients are indeed in individual rooms, but the walls of the rooms are of glass so that the patient can be observed by the nurse at the nursing station at all times.
>
> There seems to be a difference in the frequency with which the nurses observe the vital signes [sic] of the patients in the three units. Generally speaking the vital signs in the Maxicare Unit were ordered to be taken every four hours. In the ICU and CCU they were every two hours, every one, or even oftener. Of course they were on monitors which allowed their EKG to be monitored at all times.
>
> There were different numbers of nursing hours for the three units. (Trans. 5-14-81, p. 207).

Dr. Hudson admitted that the care given in the MCU was greater than that given on the routine floor. (Trans. 5-14-81, p. 229). Dr. Hudson stated that the care given in the MCU was extraordinary; however, her response to the question as to whether the care was concentrated does not appear in the transcript. (Trans. 5-14-81, p. 229). Dr. Hudson stated that the MCU care was not continuous which she defined as "all the time" because the nurses could not see the patients continuously, checked vital signs about every four hours, and had no monitoring equipment in most instances which would have given them a continuous view of the patient's electrical cardiac activities. (Trans. 5-14-81, p. 230).

Patricia Brady, a subcontract auditor for Blue Cross of Greater Philadelphia audited Metropolitan's cost report for 1978 and went on a tour of the MCU, CCU and ICU in October of 1978. (Trans. 5-15-81, pp. 10-11). Ms. Brady testified that it was the belief of the auditors that the care produced in the MCU was not continuous, concentrated and extraordinary. (Trans. 5-15-81, p. 21). She stated that there was no differentiation between the MCU rooms and the rooms on any other floor — "the

patients were walking around, the t.v.'s were on, there were telephones in there." (Trans. 5-15-81, p. 19). Ms. Brady stated that the MCU appeared to be the same as any other nursing wing of the hospital in that the patients' rooms were set up exactly as all the other floors. (Trans. 5-15-81, p. 13). Additionally, the nursing station appeared to be the same as the nursing stations in the routine areas of the Hospital: "there weren't any monitors; we couldn't see any noticeable difference between Maxicare and any other floor of the hospital, other than that area from the hallway was designated as Maxicare." (Trans. 5-15-81, p. 14). In addition, Ms. Brady analyzed the nursing hours per patient day and found a substantial difference between ICU/CCU and MCU. Ms. Brady also found the number of special care beds in the hospital to be unusually high and indicated that a study she had done on the ratio of special care beds in Philadelphia hospitals showed most hospitals with a 6.7% ratio of special care beds to total beds. Metropolitan had a 13.5% ratio. (Trans. 5-15-81, p.16).

Ms. Brady stated that the following thirteen items were the basis for her opinion that the care provided in the MCU was not continuous or extraordinary:

1. patients couldn't be seen by the nurses
2. room was set up in same manner as other routine areas
3. observed no monitoring
4. no noticeable difference and no division between MCU and floor i.e. you could just walk into the area from the elevator
5. multiple one-day stays for dialysis
6. difference in nursing uses
7. size of unit, large number of beds
8. utilization difference

9. no policy manual
10. visiting hours same as routine
11. only monitoring was available at that time to 2 telemetry units that she observed in CCU
12. transfer policy
13. TVs and telephones in the room.

(Trans. 5-15-81, pp. 43-44).

As to the issue of specific written policies, Ms. Brady testified that she had requested the *policy manual* for fiscal year ending June 30, 1978 for the Maxicare Unit from the Nursing Administrator and "[s]he told me that it did not exist for the year I wanted it for." (Trans. 5-15-81, p. 18). However, the following colloquy as to her testimony ensued between the Chairman of the PRRB and Mr. Napoli, legal representative for the intermediary:

> (Chairman) Q: "Can we cut this . . . . short by . . . stipulating that there is no requirement in the Medicare law or Regulations that a policy manual be available?"
>
> (Mr. Napoli) A: "Yes, sir."
>
> (Chairman) Q: "It doesn't have to be green, red; just written policies."
>
> (Trans. 5-15-81, p. 28).

SPECIFIC WRITTEN POLICIES

The PRRB's finding that the provider did not have specific written policies for its Maxicare Unit is not supported by substantial evidence. Further, evidence of record contradicts that finding. Along with its Post-Hearing Brief, the provider submitted Attachment 2, which contains minutes of various committee meetings relating to MCU policies and procedures. Of key importance

is a copy of the Medical Executive Committee notes dated December 5, 1973 and headed "Rules and Regulations Re: Utilization of the Maxicare Unit." (Tr. 0113-0114). These notes state the designation of the MCU: "to provide intensive, highly skilled nursing care at a level intermediate between that provided in intensive care and the coronary care unit and the care provided on the general medical and surgical nursing units." (Tr. 0113-0114). These notes of December 5, 1973 contain specific policies dealing with MCU admissions, transfers, physician orders, physician daily attendance hours, daily progress notes, procedures for daily evaluation of patient nursing needs, and procedures for resolution of disagreements on transfers out of MCU. On the basis of these notes alone, the PRRB could have found substantial evidence to support a conclusion that the MCU did in fact have specific written policies.

Our review of the transcript and post-hearing brief materials indicates that other specific written policies relating to the MCU were made available to the PRRB prior to its decision. These include the following:

1. Critical Care Committee Meeting Notes of September 20, 1977 setting forth the policy of authority on daily decisions on patients in MCU and on transfers. (Tr. 0117).

2. Nursing personnel memorandum regarding the policies governing the administration of IV medications, dated July, 1977. (Tr. 0129-0133, and 0168-0184).

3. Nursing procedures relating to: calibration of the A-V pressure monitor for catheter (Tr. 0147-0148); continuous monitoring for nursing care (Tr. 0150); utilization of blackmore tube to stop hemorraging (Tr. 0151-0153); peritoneal dialysis procedure (Tr. 0154-0156); care of patient with a Swan-Goz Pulmonary artery catheter (Tr. 0157).

4. Policy and procedure memorandum for cardiac monitoring by a telemetry on MCU and ICU, dated July 13, 1977. (Tr. 0189-0190).

In addition to these specific written policies, all four of the witnesses for Metropolitan Hospital testified that these specific written policies existed. The intermediary's witness, Ms. Brady, indicated in her testimony that the fact that no manual was produced for her led her to the conclusion that no specific written policies existed. However, the language of the regulation is clear in that it only requires specific written policies and not a manual, as the Chairman for the PRRB noted. Accordingly, we find that several specific written policies relating to the MCU's admissions, transfers, and nursing care procedures were submitted to the PRRB for their consideration prior to their final determination. The PRRB's ultimate decision that the MCU did not have specific written policies is against the weight of the evidence submitted and is supported by no evidence. Accordingly, its decision as to this issue should be reversed as it is not supported by substantial evidence.

EXTRAORDINARY CONTINUOUS AND CONCENTRATED CARE

The intermediary and defendants in this case contend the characterization that care provided by the MCU was extraordinary, continuous and concentrated. Put quite simply their position on this issue seems to be that the MCU provides an "intermediate" level of care falling below that provided in ICU/CCU yet being above that of the routine surg/med floors. Because this care is below that of an intensive care unit, it is not therefore that of a special care unit. This analysis is unavailable in that it deviates from the language of the regulation.

It has been noted by this Court that "intensive" care is not an element required by 42 C.F.R. §405.452(d)(10). *Rolling Hill Hospital, Inc. v. PRRB*, E.D. Pa. No.

76-1878 (Nov. 10, 1977), CCH Medicare and Medicaid Guide, ¶28, 745. Further, this Court is not bound to accept the intermediary's or the PRRB's reliance on interpretive regulation §2202.7 (Provider Reimbursement Manual, Part I, §2202.7), or the interpretive regulation itself, and it has been held error on the PRRB's part to apply it retroactively. *Rolling Hill Hospital, supra.*

The intermediary and the PRRB seemed to be applying extra criteria in determining that Metropolitan Hospital was not a special care unit. We are bound by the language in the regulation as has been stated in *Rolling Hill Hospital, supra.*

> Since Congress did not consider the language in the regulation promulgated by the Secretary and here in issue, we do not have the aid of legislative history. The regulation itself is all we have to go by. The six elements, and only those elements, are those which the law and the regulations require in order for the Unit to be considered a special care inpatient hospital unit. The regulation does not attempt to describe all the types of special care units that would qualify.

It is this Court's opinion that the care provided by the MCU was extraordinary, continuous and concentrated. The PRRB's finding to the contrary is not supported by substantial evidence and misconstrues the regulation applicable to this case. A careful examination of the record in this case reveals that the provider has by a preponderance of evidence shown that the nursing care provided in the MCU was extraordinary, continuous and concentrated. Accordingly, the PRRB decision on that issue should be reversed as it is not supported by substantial evidence.

BORROWED FUNDS AND DEPRECIATION

Metropolitan Hospital seeks reversal of the PRRB's decision that interest expense of $52,054.00 on borrowed funds is not reimbursable in this case. 42 C.F.R. 405.419 provides that necessary and proper interest on both current and capital indebtedness is an allowable reimbursable cost. Interest is the cost incurred for the use of borrowed funds. The term "necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the hospital and for a purpose reasonably related to patient care. *See, Provider Reimbursement Manual,* Part 1, §200, 202.1, 202.2, and 202.3. However, interest on money borrowed to fund depreciation is not an allowable cost under *Provider Reimbursement Manual,* Part 1 §226.5. The intermediary has disallowed interest payments of $52,054.00 on money borrowed during fiscal year 1978 on the theory that the money was borrowed to fund depreciation. The PRRB affirmed the intermediary's determination. Metropolitan claims that the money it borrowed was done so to meet a financial need and to provide patient care, not to fund depreciation. Metropolitan claims that the interest should be a reimbursable cost. This Court finds the Hospital's claim to be without merit.

Paul Detky, Metropolitan Hospital Administrator of Fiscal Affairs and a certified accountant testified for the hospital as to this issue. (Trans. 5-15-81, p. 59). Mr. Detky stated that he prepared a prospective cash flow for fiscal year 1978 which planned to borrow $1.5 million from Provident National Bank and Central Penn (Trans. 5-15-81, p. 70). He stated that provisions are made at the beginning of the fiscal year to borrow money from a bank or commercial lender because not-for-profit institutions such as Metropolitan are running at least 90 days behind in the payments from the intermediaries. (Trans. 5-15-81, p. 64).

Mr. Detky testified that in May-June of 1978 there was an interregnum of Medical Assistance patients who are paid in part by the state and the hospital was required to borrow money to meet their costs. (Trans. 5-15-81, pp. 71-72). Loans were drawn as follows: 8-10-77, $35,000 from Central Penn; 11-1-77, $25,000 from Provident; 12-19-78, $735,000 from Central Penn; 2-1-78, $250,000 from Provident; 6-12-78, $300,000 from Central Penn; 6-30-78, $200,000 from Central Penn, totaling $1.845 million. (Trans. 5-15-81, p. 77). Mr. Detky stated that the last two loans were taken because of the Medical Assistance Interregnum and because the state legislature had not passed their budget which would have included in part moneys to be paid to Metropolitan. (Trans. 5-15-81, p. 78). Mr. Detky testified that all of the loans were used to liquidate accounts receivable, i.e., it was to have been used for wages, salaries, and supplies, and further that the borrowings were used for ongoing operations and were not related to the funded depreciation. (Trans. 5-15-81, p. 90).

Mr. Detky stated that there had been occasions in the past when capital deficiencies prevented the Hospital from funding depreciation prior to fiscal year 1978. (Trans. 5-15-81, p. 84). He also testified that on December 29, 1977 funded depreciation was added to in the amount of $250,000 from Central Penn; $225,000 from Provident, for a total of $475,000. (Trans. 5-15-81, p. 74). Additionally, depreciation was funded on January 26, 1978, January 31, 1978, and March 23, 1978. Mr. Detky also testified that in December of 1977, the hospital's cash collections totalled the highest of the fiscal year — $2,306,000.00. (Trans. 5-15-81, pp. 74-75). Lastly, Mr. Detky testified that for fiscal year 1978, the depreciation account increased $560,000.00 and the working capital went down $262,000.00. (Trans. 5-15-81, p. 99).

Emanuel Lauria, Jr., an expert in the field of health care accounting and third party reimbursement was in the charge of a subcontract auditing for Blue Cross of Greater Philadelphia and at the hearing reviewed the audit done on Metropolitan for fiscal year 1978. (Trans. 5-15-81, p. 104). Mr. Lauria concluded that the moneys borrowed by MCU were borrowed to fund depreciation. (Trans. 15-15-81, p. 106). Mr. Lauria stated that the borrowing was unnecessary and noted that the hospital had not funded depreciation in the past. (Trans. 5-15-81, pp. 111-112). Mr. Lauria noted that the depreciation fund was added to in relatively short periods of time, that some funding of the depreciation occurred in the same months as loans were obtained, and that one such funding was made in the exact same Journal entry as the loan was. (Trans. 5-15-81, p. 120).

Based on this testimony and the documents submitted, the Board concluded:

> The Provider claims that the funds were borrowed to meet the decline in working capital and current capital indebtedness. The question to be asked is, how can a provider continue to fund depreciation when there are working capital deficiencies? The borrowing of money and corresponding investment of the funds is contrary to Medicare's regulations and program instructions. Prudent management would dictate the halt of funding depreciation when working capital deficiencies exist.
>
> (Tr. 0021.)

This Court finds the Board's decision is supported by substantial evidence. We fail to see how Metropolitan can claim that the moneys it borrowed were not used to fund depreciation when in fact the plaintiff's depreciation account increased significantly in fiscal year 1978 while its capital account carried a substantial deficiency. This is especially true in light of the hospital's own testimony that its cash collections for December, 1977

totalled in excess of two million dollars. The provider urges that the intent of the provider in the actual use of the borrowed money should control its characterization and utilization. We view the issue however as a factual one, not one concerning intent. If the hospital had presented factual documentation indicating how the moneys borrowed were spent on patient care, we would have before us a record containing specific instances of showing how the money was used. However, all we have is conflicting assertions of how certain transactions are to be characterized. In the absence of specific factual data indicating that the hospital utilized its borrowed funds for its operations, we feel that the PRRB's decision, based as it is on rather incriminating evidence, is supported by substantial evidence which was not properly rebutted by the provider.

Accordingly, this United States Magistrate makes the following:

RECOMMENDATION

NOW, this 25th day of October, 1982, IT IS RESPECTFULLY RECOMMENDED that the defendant's decision as to the first and second issues concerning the Metropolitan Hospital Maxicare Unit is Reversed and as to the third issue concerning interest on loans for fiscal year 1978 is affirmed. IT IS FURTHER RECOMMENDED that the Plaintiff's Motion for Summary Judgment be Granted as to Issues 1 and 2 and Denied as to Issue 3; and the Defendant's Motion for Summary Judgment be Denied as to Issues 1 and 2 and Granted as to Issue 3.

EDWIN E. NAYTHONS
UNITED STATES
MAGISTRATE

APPENDIX D

Provider Reimbursement Review Board
Hearing Decision
82-D26

Provider — Metropolitan Hospital
Philadelphia, Pennsylvania

Provider No. — 39-0059

Intermediary —Blue Cross Association
Blue Cross of
Greater Philadelphia

Date of hearing
May 14, 1981

Cost Reporting Periods
Ending—June 30,
1977 & 1978

Case No. 809-56

Index

	Page No.
Issue	2
Summary of Facts	2
Citation of Applicable Law, Regulations, and Program Instructions	6
Conclusions and Findings	6
Decision	9

Issues:

1. Whether the Intermediary correctly refused to permit the Provider to treat the Maxicare Unit as a "special care unit" under Section 405.452(d)(10) of the Regulations?
2. Whether the Intermediary was correct in determining that money was borrowed to fund depreciation and disallowing the interest expense on the money borrowed for the FYE June 30, 1978?

Summary of Facts:

The Provider is a 215-bed, acute-care, short-term, nonprofit, general hospital.

In 1971, the Provider opened a "Maxicare Unit" (MCU), to go along with its already established Cardiac Care Unit (CCU) and a Surgical Intensive Care Unit (ICU). The MCU was treated and classified by both the Provider and the Intermediary as a Special Care Unit (SCU), pursuant to the regulations, and was treated as such until February 9, 1979. On that date, the Intermediary advised the Provider that the 19-bed MCU would no longer be considered a SCU, but would be considered a "routine care unit," for Medicare reimbursement purposes.

As a result, the Intermediary reopened the cost years for 1976 and 1977 and adjusted the Provider's costs from special care to routine care. A reclassification was also made to the FYE June 30, 1978, then under review.

The rationale for the change in position was contained in Section 2202.7, PRM (HIM-15), which was attached to the letter of February 9, 1979, reclassifying the costs involved.

On February 28, 1980, the Intermediary filed a Revised Notice of Program Reimbursement for the fiscal years 1976 and 1977 to effectuate the reclassification of costs. The effect for the years ending 1976 and 1977 was $5331 and $173,439, respectively. The Notice of Program Reimbursement dated November 26, 1979, for the FYE 1978 reduced Medicare reimbursement on the reclassification issue by $280,141.

In addition, the Intermediary disallowed interest expense, for the FYE 1978, on monies borrowed by the Provider on the basis that the borrowing was made to fund depreciation (42 CFR 405.419, Section 226.5, PRM (HIM-15)). The Medicare reimbursement affected by this adjustment is $52,054.

The Provider timely filed Requests for Hearing for the FYE's 1976, 1977 and 1978, pursuant to Section 1878, Title XVIII, Social Security Act, as amended and 42 CFR 405.1835ff. The Board, however, dismissed the appeal for the FYE 1976, as there was less than $10,000 of

Medicare reimbursement at issue for that cost reporting period (42 CFR 405.1835(a)(3) and (42 CFR 405.1839). The Provider may avail itself of an Intermediary Hearing for the 1976 dispute.

The Intermediary's review of the MCU disclosed that two of the conditions set forth under 42 CFR 405.452(d)(10) had not been met. Specifically, the facility had no written policies or procedures for the MCU and the care provided was not extraordinary, concentrated or continuous, to the extent that it constituted special care.

Attachment 2, *Provider's Post-Hearing Brief* denotes in its "Rules and Regulations Regarding Utilization of the Maximum Care Unit" that

"The Maximum Care Unit is designed to provide intensive, highly skilled nursing care at a level *intermediate between that provided in Intensive Care and Cardiac Care Unit* (individualized care with constant surveillance and monitoring) *and the care provided on the general medical and surgical nursing units.*" (Emphasis supplied.)

To the Intermediary, this statement, rendered by the Provider, confirmed that the MCU was an "intermediate" care unit, not a special-care unit.

The Intermediary concluded that "The Provider did not have a policy and procedure manual available for use in the daily operations prior to July 1978. A review of the existing manual disclosed that less critically ill patients were admitted to the unit and 39% of the admissions were from the ICU and CCU patient area, with many discharges directly from the area. Additionally, the visiting policies were similar to the routine patient care areas. The Provider's charge structure for 1978 shows that the maxi-care charge was similar to the routine area charge. This evidence again established that the unit does not qualify as a special care unit." (*Intermediary Position Paper*, pp. 29-30).

According to the Intermediary, the nursing hours per patient day comparisons disclosed that the staffing levels in the MSU were much less than that in the CCU and ICU.

The Provider, on the other hand, disputed the Intermediary's conclusions, noting that the facility had had policies and procedures in existence controlling the operation of the MCU (*Provider Post-Hearing Submission* dated July 22, 1981). In addition, minutes of the various committees in the hospital area provided to show the uniform approach taken in the MCU area.

As to the types of care rendered, the Provider offered a plethora of witnesses to substantiate the level involved. Further, the Provider contended that the "reversal" of Medicare policy, leading to the reclassification and reopening, was attributable to a "change" in the controlling program instruction, Section 2202.7, PRM (HIM-15); that the change was "rule-making" without following the format prescribed under the Administrative Procedures Act (APA), 5 U.S.C. Section 551 et. seq., and not a "clarification of existing policy" as advanced by the Intermediary.

With regard to Issue No. 2, the Provider argued that 42 CFR 405.419, provides that necessary and proper interest on both current and capital indebtedness is an allowable cost. Since the money was borrowed for its financial need *and* for patient case, the interest, according to the Provider, should be allowed as a deduction.

The Intermediary contended that borrowings from November 30, 1977, to May 31, 1978, were not necessary. The Provider claimed that the funds were borrowed to meet a decline in working capital and current capital indebtedness. The Intermediary argued that the Provider should not have continued to fund depreciation if working capital deficiencies existed.

The Intermediary's auditor adjusted Schedule A-8, to reflect a disallowance of $52,054, in interest expense

related to monies borrowed to fund depreciation. A letter dated January 20, 1981, from its Auditor *(Intermediary Position Paper,* Exhibit D) explained the reasons for the adjustment.

The facts disclose the fund balance activity in the board designated funds (funded depreciation) as follows:

Balance at beginning of year	$1,098,246
Income from investments	50,737
Funded Depreciation	533,000
Balance at end of year	1,681,983

1. The Provider's records indicated that at November 30, 1977, the investments in the funded depreciation account totaled $215,680.16, while the remaining note(s) payable equalled $225,000.

2. During December 1977, the Provider borrowed $225,000 and purchased a saving certificate in a similar amount from Provident Bank.

3. Also during December 1977, Central Penn Bank was paid the balance of its note ($225,000). In addition, the Provider borrowed an additional $735,000 which is a net increase in notes payable from November 30, 1977 of $510,000. The investment (savings certificates) in the funded depreciation account increased $587,320. These investments are with the same banks that hold the notes payable.

4. In January 1978, the Provider increased its note payable to Provident and increased its saving certificates in that bank by $250,000. Also, approximately another $200,000 plus interest was added to the investments bringing the total in the funded depreciation account at January 31, 1978, to $1,256,923 while the notes payable totaled $1,210,000

5. The only other note payable activity was in June 1978, when the Provider borrowed an additional $600,000 bringing the total borrowing at June 30, 1978, to $1,810,000.

The activity in the funded depreciation investment account from February 1, 1978, to June 30, 1978, consisted basically of rolling over various saving certificates and accumulating interest income. At June 30, 1978 and 1977, the savings certificates and notes payable were as follows:

Bank	Saving Certificates	Notes Payable
Central Penn	$ 795,736.10	$1,335,000.10
Provident	487,136.79	475,000.00
1978 Totals	$1,282,872.89	$1,810,000.00
Central Penn	$ 436,829.94	$ 450,000.00
Provident	—	225,000.00
1977 Totals	$ 436,829.94	$ 675,000.00

Based upon the above analysis according to the Intermediary, the Provider borrowed monies to fund depreciation. From November 30, 1977, to May 31, 1978, the saving certificates and notes payable were equal except for interest earned. The following relationship existed between borrowed funds and saving certificates in the funded depreciation account at May 31, 1978:

Bank	Saving Certificates	Notes Payable
Central Penn	$ 788,279.46	$ 735,000.00
Provident	478,951.62	475,000.00
	1,267,231.68	1,210,000.00

Based upon the above analysis, the Intermediary questioned the necessity of the loans. Since the saving certificates and notes payable were with the same banks it had the appearance that the certificates were pledged as security for the notes.

CITATION OF APPLICABLE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

I. *Regulations* —42 CFR 405
1. Section 405.419 —Interest Expense
2. Section 405.452(d)(10) —Intensive Care type Inpatient Hospital Unit

II. *Program Instructions*
1. Section 2202.7 —Special Care Unit
2. Section 226 (226.1-226.5) —Funded Depression

CONCLUSIONS AND FINDINGS:

The PRRB, after consideration of the facts, parties contentions, evidence presented and testimony elicited at the Hearing, concludes and finds that the Intermediary's adjustments are correct and are affirmed.

Special Care Unit:

The reclassification of costs pertaining to the MCU was based upon the Intermediary's conclusion that two aspects of Section 405.452(d)(10) had not been met. The two requirements of the four enunciated by the Regulation, were (1) the unit must have specific written policies and (2) must provide care which is extraordinary and do so on a concentrated and continuous basis.

With regard to the first condition, it appears that no specific manual or instructions existed *during* the period in question; at least documentation was not made available to the Intermediary sufficient to satisfy this prerequisite. It is noted that the Provider submitted documentation by post-hearing procedure (*Provider's Post-Hearing Brief*, Attachment 2), which appears to affirm the status of the unit in question, i.e., that it is an "intermediate unit."

While the Provider avers that written policies were in existence during the period in question, it appears that the only policies generally discussed were those contained in the Minutes of the Critical Care Committee.

Also, it was questionable whether the hospital staff was apprised of such procedures.
The Intermediary made a thorough comparison of the MCU with the CCU/ICU and Routine Care areas:

1. The nursing hours per patient day comparisons clearly demonstrate that the staffing levels in the MCU were considerably less than that in the CCU/ICU. Indeed, in terms of nursing care, the MCU is more comparable to the routine area.

2. A comparison of the Provider's charge structure denoted that the MCU charges were only 13% higher than routine areas.

3. A review of the admissions policy denoted that 39% of the patients admitted to the MCU were from the ICU/CCU. This established that a significant number of the patients were transferred from a more intensive level of care to a lower level of care. Further, it was disclosed that many of the patients were discharged directly from the MCU, which normally does not occur from an intensive level of care area.

4. The visitor's policy denoted that the MCU was similar to routine.

While the Board agrees that nursing hours are not the sole criterion in a determination of whether a unit is receiving extraordinary, concentrated and continuous care, the Board finds that the comparison in the present case is difficult to surmount.
Furthermore, the Board finds that the evidentiary material submitted does not constitute, substantial evidence, in the light of Medicare requirements, to support a finding that the care rendered was extraordinary, concentrated or continuous.
In *John Muir Memorial Hospital, Inc., v. Harris*, U.S.D.C., N. D. of California, C 79 2686 RFP, June 25,

1980, the Court supported the Board's conclusion that a Definitive Care Unit (DCU) qualified as a SCU. While the Court and the Board were satisfied in that case that the care rendered was extraordinary, concentrated and continuous, we do not arrive at the same conclusion in this case. The Board has reached this conclusion on the basis of Section 42 CFR 504.452(d)(10), and without benefit of clarification rendered by section 2202.7. In *John Muir, supra,* the Court held only that section 2202.7, may not be applied retroactively, but declined to decide whether that revision was a "substantive" change and thereby invalid for procedural irregularities.

Responding to the Provider's argument that the care provided in its MCU was "equal to that provided in the ICU/CCU, the Board refers to *Saint Luke's Hospital of Bethlehem, Pennsylvania v. Schweiker,* U.S.D.C., E.D. of Pennsylvania; Civil Action No. 80-1710, August 12, 1981, wherein the Court reversed the Administrator on this point. The Court concluded that the test is not whether the care is equal, but whether it meets the extraordinary, concentrated and continuous requirement.

As final support, the Board cites *Glendale Adventist Medical Center et al., v. Schweiker,* U.S. Court of Appeals, Ninth Circuit, Nos. 79-3204, April 3, 1981, wherein the Court found that the Secretary's interpretation of Section 405.452, requiring units to render a level of care similar to that enumerated (i.e., ICU/CCU) in the Regulation was reasonable. The Court concluded that intermediate care units were not special care inpatient hospital units within the meaning of Section 405.452(d)(10).

Interest Expense:

The Provider has not demonstrated that the borrowings were used for purposes other than to satisfy its own funded depreciation needs.

The Provider claims that the funds were borrowed to meet a decline in working capital and current capital indebtedness. The question to be asked is, how can a provider continue to fund depreciation when there are working capital deficiencies? The borrowing of money and corresponding investment of the funds is contrary to Medicare's regulations and program instructions. Prudent management would dictate the halt of funding depreciation when working capital deficiencies exist.

The Intermediary auditor's conclusion (*Intermediary Position Paper,* Exhibit D) conclusively stated that the Provider borrowed monies to fund depreciation. The adjustment to disallow interest expense on the notes payable from November 30, 1977, to May 31, 1981, based on the fact that the borrowing was not necessary (section 405.419) and the fact that the borrowing was used to fund depreciation (Section 226, PRM (HIM-15)), is proper.

DECISION:

1. The Intermediary's determination that the Provider's Maxicare Unit did not qualify as a Special Care Unit, under the Medicare program is correct.
2. The Intermediary was correct in determining that money was borrowed to fund depreciation and properly disallowed the interest expense incurred on the money borrowed for the FYE June 30, 1978.

Board Members Participating

Thomas M. Tierney
James Houdek, Jr., CPA
Bette A. Kraus

FOR THE BOARD

December 21, 1981

Thomas M. Tierney
Chairman

APPENDIX E

UNITED STATES COURT OF APPEALS
For The Third Circuit

No. 83-1566

METROPOLITAN HOSPITAL,

Appellant

v.

PROVIDER REIMBURSEMENT REVIEW BOARD OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, TIERNEY, Thomas M., HOUDEK, James Jr. and KRAUS, Bette A.

SUR PETITION FOR REHEARING

Present: SEITZ. *Chief Judge*, ALDISERT, ADAMS, GIBBONS, HUNTER, WEIS ,GARTH, HIGGINBOTHAM, SLOVITER and BECKER, *Circuit Judges,* and STAPLETON,* *District Judge*

The petition for rehearing filed by

APPELLANT

in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

By the Court,

/s/ JAMES HUNTER

Judge

Dated: July 3, 1984

*Honorable Walter K. Stapleton, United States District Judge for the District of Delaware, sitting by designation.

APPENDIX F

42 U.S.C. 1395x

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such

regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

APPENDIX G

42 U.S.C. § 1395hh. Regulations

The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

APPENDIX H

42 C.F.R. §405.452(d) (10)

Intensive care units, coronary care units, and other special care inpatient hospital units. To be considered an intensive care unit, coronary care unit, or other special care inpatient unit, the unit must be in a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general patient areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units but exclude post operative recovery rooms, post-anesthesia recovery rooms or maternity labor rooms.

APPENDIX I

42 C.F.R. §405.452

(d) *Criteria for identifying intensive care type units.* For purposes of determining costs under this section, a unit will be identified as an intensive care type inpatient hospital unit only if the unit—

(1) Is in a hospital;

(2) Is physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas. There cannot be a concurrent sharing of nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the intensive care type unit. If a float nurse works in two different units during the same eight hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those units. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine services cost areas;

(3) Has specific written policies that include criteria for admission to, and discharge from, the unit;

(4) Has registered nursing care available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;

(5) Maintains a minimum nurse-patient ratio of one nurse to two patients per patient day. Included

in the calculation of this nurse-patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians, and housekeeping personnel; and

(6) Is equipped, or has available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

APPENDIX J

"Special Care Units (Prov. Reimb. Man., Part 1, §2202.7).

"To be considered a special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care rendered is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general care areas. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms, postanesthesia recovery rooms or maternity labor rooms. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuro-psychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment, unless the above requirements are met."

APPENDIX K

"Special Care Units (Prov. Reimb. Man., Part 1, §2202.7).

"A. Requirement to Qualify as an SCU. — To be considered a special care hospital unit, the following requirements must be met:

"1. The unit must be in a hospital.

"2. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive life-saving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma and intensive care units. For this reason, special life-saving equipment should be routinely available in the unit.

"3. The unit must be physically identifiable as separate from general care areas and the unit's nursing personnel must not be integrated with the general care nursing personnel.

"4. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms or maternity labor rooms. The unit's staff must be specially trained to serve in such areas. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment unless the above requirements are met.

. . .

"B. Subintensive Units. — Some hospitals have units which provide more intensive care than that provided in

the general care areas yet not sufficiently intensive to permit the unit to meet the requirements to qualify as a special care unit under the definition provided in paragraph A above. These units are typically designated as subintensive, subacute, progressive, or intermediate care units, etc. Such subintensive units are not special care units for purposes of Medicare reimbursement.

"There may, however, be cases where a unit is not easily identified as a subintensive or special care unit without further study. In such cases, a review of the written policies of the various units will indicate whether a unit is or is not providing care as defined in paragraph A. If the intermediary determines that such a unit meets the requirements of paragraph A above, then the unit will qualify as as special care unit.

"For example, one indication of whether the unit in question meets the requirements specified in §2202.7A2 is the extent of nursuing services provided in the unit. If the hours of nursing service per patient day are less than the hours of nursing services provided in an established special care unit, such as an ICU or CCU in that hospital or in other area hospitals if the hospital has no established special care unit, then the unit in question would generally not qualify as a special care unit. Hospitals should maintain such records as are needed to establish the nursing time in such units. . . . " (Add. II) (Emphasis supplied).

APPENDIX L

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
[42 CFR Part 405]

Medicare Program; Definition of Hospital Special Care Units for Reimbursement Purposes

AGENCY: Health Care Financing Administration (HCFA), HEW.
ACTION: Proposed rule.

SUMMARY:

This rule refines the definition of hospital special care units and clarifies the requirements for their reimbursement under the Medicare program. The present special care unit reimbursement regulation has been erroneously interpreted by some hospitals to apply to units that furnish a level of care that is less than that furnished in intensive care.

Under the present regulation, units have been designated as special care units, when they are, in fact, intermediate or subintensive care units that render a less intensive level of care. The purpose of this amendment is to clarify the intent of the regulation that the term "special care unit" applies only to those units rendering a level of care that is comparable to intensive care.

DATES:

Consideration will be given to written comments or suggestions received on or before July 16, 1979.

ADDRESSES:

Address comments to: Administrator, Health Care Financing Administration, Department of Health, Edu-

cation and Welfare, P.O. Box 2372, Washington, D.C. 20013. When commenting, please refer to MAB-84-P. Agencies and organizations are requested to submit their comments is duplicate. The Health Care Financing Administration specifically requests comments and supporting data, if possible, on §405.412(d)(10)(v) and (vi) of the proposed regulation. Comments will be available for public inspection, beginning approximately 2 weeks after publication, in room 5231 of the Department's offices at 330 C Street, S.W., Washington, D.C. on Monday through Friday of each week from 8:30 to 5 p.m. (telephone 202-245-0950).

FOR FURTHER INFORMATION CONTACT:

William Goeller, Medicare Bureau, Health Care Financing Administration, Room 405 East High Rise Building, Baltimore, Maryland, 21235, (301) 594-9820.

SUPPLEMENTARY INFORMATION:

Section 1881 (v) of the Social Security Act provides that the Secretary may establish, by regulations, the methods to be used in determining the reasonable costs of services furnished to Medicare beneficiaries. The methods used in reimbursing providers are based on costs actually incurred in furnishing services to beneficiaries. The regulations recognize that different types of care may result in different per-diem costs. The per-diem cost of intensive care and other special care units will usually exceed the per-diem cost of general routine care. This is because intensive care units require greater staffing and more specialized equipment than what is required in the general routine areas. Thus, the present regulations allow for a separate computation to determine Medicare's share of intensive care and other special care unit costs as well as its share of general routine care costs.

Recently, some hospitals have designated as special care units, units that provide various levels of care. These units provide a level of care which is less than provided in intensive care and more than furnished in the general routine areas of the hospitals. The cost of operating these units falls somewhere between those of operating intensive care units and the cost of furnishing general routine care. These units, sometimes referred to as intermediate or subintensive care units, are frequently cited as a way to reduce hospital costs. When they are used as step-down units from intensive care or to avoid the intensive care unit altogether, hospital costs are reduced. Yet, if the hospitals receive reimbursement for these units as special care units, Medicare reimbursement will be inequitably increased. Notwithstanding that many of the intermediate or subintensive care units provide a level of care which is less than intensive care, some hospitals contend that the units should be designated and reimbursed as special care units under the current regulation.

Since the adoption of the special care unit reimbursement policy, we have maintained that only those units rendering a level of care comparable to intensive care should be reimbursed as special care units. We maintain that a subintensive level of care is only a part of the spectrum of general routine care. Although a subintensive care unit may not fit the regulatory description of a special care unit, we will reimburse for the care rendered in that unit by combining the reasonable costs of care in that unit with the reasonable costs of care in other general routine areas. Any reimbursement for general routine service costs, however, will include an inpatient routine nursing salary cost differential, and be subject to the schedule of limits on hospital inpatient general routine service costs.

Several recent Provider Reimbursement Review Board and Federal court decisions have addressed the issue of whether intermediate or subintensive care units

are special care units and have come to varying conclusions. These decisions show an existing lack of uniformity as to what constitutes a special care unit. In addition, since the regulation was issued, substantial changes have occurred in hospital organization, administration, and financial practices. Increasingly, the inpatient hospital special care unit concept has become an acceptable part of medical care practice. We perceive a definite need to further refine and clear away ambiguity as to what a special care unit is for Medicare reimbursement purposes. Thus, we propose to amend the regulation.

The amendment would clarify the regulation by providing seven specific criteria which a unit must meet to qualify as a special care unit. One such criterion is that there must be a minimum of 12 scheduled hours of direct patient nursing care per patient day. This 12 hour figure is based on data contained in the American Hospital Association's periodic publication of Hospital Administrative Services data for the period ending December 31, 1977. This information indicates that the great majority of hospitals have at least 12 hours of such care per patient day in their intensive care units.

Another criterion is that a minimum of 6 hours of direct patient care per patient day must be furnished by registered nurses and cannot be furnished by aides or orderlies. As a result of a sample of rural and urban hospitals, we concluded that at least 6 hours of direct patient-care is normally furnished by registered nurses in intensive care type units. This criterion takes into consideration that the level of required registered nursing care in special care units is considerably higher than the level that is required in general routine areas. In most cases, only registered nurses possess the necessary expertise for furnishing care to patients in special care units. In no case would aides or orderlies satisfy the requirement.

The other criteria specify that the unit must be in a hospital, must be physically and identifiably separate

from other areas and units in the hospital and must have specific written policies concerning admission, discharge and other matters. In addition, the unit must be permanently equipped with life-saving equipment to treat the critically ill patients for whom it is designed, and registered nursing care must be furnished daily on a continuous 24-hour basis. We invite comments on whether the admission and discharge policies for special care units must be consistent with the standards set by the PSRO's and must be approved in advance by PSRO's. (Proposed regulations on PSRO hospital review were published in the Federal Register on January 25, 1977 and final regulations will be published soon.

APPENDIX M

¶28,678 PRRB DECISION—DEFECTIVE NPR—JURISDICTIONAL AMOUNT IN GROUP APPEAL—DEFINITIVE OBSERVATION UNITS/INTERMEDIATE CARE UNITS AS SPECIAL CARE UNITS

PRRB Hearing Dec., No. 77-D76, Oct. 28, 1977 (cost reporting periods 1974 and 1975).

Notices, determinations, and appeals—Defective Notice of Program Reimbursement.—Although the Notices of Program Reimbursement issued by an intermediary did not fully conform with the regulations, in that they did not adequately explain the basis for a disallowance, the NPRs were procedurally sufficient for the Board to attach jurisdiction. Nor did the defective NPRs deny providers a fair hearing before the Board, since the providers were aware of the audit adjustments and rationale for the adjustments prior to the hearing. The Board noted that the parties had been directed, several months prior to the hearing, to fully discuss the matters in dispute, and that adequate notice was given to the parties of the issues to be heard through the position papers and the hearing notice. *Back reference* ¶13,510.64.

Notices, determinations, and appeals—Group appeal—Jurisdictional amount.—In a group appeal, the jurisdictional amount of $50,000 or more must be satisfied by the group for each cost reporting period, the contention that there is no basis in the regulations for the determination that the jurisdictional amount has to be satisfied for each reporting period in a group appeal being rejected. A contrary conclusion was not required on the ground that strict adherence to this interpretation could preclude almost all but identical fiscal year group appeals. *Back reference* ¶13,510.69.

[Summary by PRRB]

[Provider reimbursement—Determination of cost of services to beneficiaries—Special care inpatient hospital units—Definitive Observation Units/ Intermediate Care Units.—A group of three providers appealed the decision of the Intermediary to reclassify patient days and costs of Definitive Observation Units/Intermediate Care Units (DOU/IMCU) from the special care category to general routine care. This reclassification reduced Medicare reimbursement. The Intermediary based its decision primarily on the fact that the average amount of nursing care was less than in ICUs and CCUs although considerably more than in the general patient care areas. The Board considered that comparisons of nursing care alone were insufficient to determine whether a DOU/IMCU could be classified as a "special care inpatient unit" for purposes of Medicare reimbursement. Therefore, the board allowed recognition of the DOU/IMCUs as special care units and reversed the Intermediary's decision. *Back reference* ¶6096.]

Caution the PRRB states that its "decisions are binding only as to the parties involved and for the particular cost reporting period involved. These decisions, do not serve as precedents for other providers in future appeals."

[Text of Decision]

Issue

Whether the Intermediary correctly refused to permit the providers to treat the Definitive Observation Units/Intermediate Care Units as "special care inpatient hospital units," as that term is defined in Regulation §405.452(d)(10)?

Statement of Facts

Provider A, Provider B, and Provider C are all general, short-term hospitals. Providers A and B are voluntary, nonprofit, church-related hospitals; Provider C is a nonprofit corporation hospital.

The pertinent statistical information for the year under appeal is as follows:

	Fiscal Year Ending	Number of Beds	Percent of Occupancy	Medicare Utilization
Provider A	12/31/74	444	79%	49%
Provider A	12/31/75	441	78%	48%
Provider B	12/31/74	302	83%	40%
Provider C	9/30/75	498	75%	46%

The issue is concerned with whether the multipurpose special care units (DOU/IMCU) established by the providers qualify as special care inpatient hospital units within the meaning of Regulation §405.452(d)(10). These units were developed by the providers, which had determined that, if multipurpose special care areas with relatively high-density nursing were provided, more cost-effective utilization of space and services would result.

The Intermediary, during its Medicare audits, determined that the providers' multipurpose units did not qualify as special care units. Accordingly, it made adjustments to reclassify the patient days, costs, and revenues for these units from the special care category to the general routine care category for determining allowable costs for Medicare purposes.

The providers have raised two procedural issues in its appeal. The first challenges the adequacy of each Notice of Program Reimbursement (NPR) issued by the Intermediary. The providers contend the Intermediary

has not explained the basis for disallowing costs of the DOU/IMCU special care units, as required in Regulation §405.1803 and §2606 of HIM-13-2, *Part A Intermediary Manual*, Part 2. Therefore, the providers assert that the NPRs are defective.

The second procedural issue challenges the Board's determination that the jurisdictional amount ($50,000 or more) must be satisfied for each cost reporting period in a group appeal by the providers. In a March 31, 1977 letter to their representatives, the Board stated it had considered the providers' objections, but reaffirmed its position that the jurisdictional amount of a group appeal must be met for each cost reporting period.

The Intermediary issued a Notice of Program Reimbursement to each provider for the appropriate cost reporting periods as follows:

	F/Y/E	Date of NPR	Date of Appeal Request	Amount in Controversy
Provider A	12/31/74	04/30/76	10/22/76	$ 15,854
Provider B	12/31/74	11/19/76	02/14/77	44,090
Subtotal				$ 59,944
Provider A	12/31/75	12/30/76	02/18/77	$ 46,213
Provider C	09/30/75	10/07/76	02/14/77	11,000
Subtotal				$ 57,213
Total				$117,157

Pursuant to 20 CFR 405, Regulations No. 5, Subpart R, §405.1841, the providers filed a timely request for a hearing before the Provider Reimbursement Review Board as shown above. A hearing was held in June 1977.

Citation of Applicable Law, Regulations, and Program Instructions

	Appendix
I. *Regulations—20 CFR 405, Regulations No. 5, Subpart D* 1. 20 CFR 405.452(d) (10) [recodified as 42 CFR §405.452(d) (10)]—Determination of Cost of Services to Beneficiaries—Intensive Care Units, Coronary Care Units, and Other Special Care Inpatient Hospital Units	A [omitted, see ¶6025]
II. *Regulations—20 CFR 405, Regulations No. 5, Subpart R* 1. 20 CFR 405.1803 [recodified as 42 CFR §405.1803]—Intermediary Determination and Notice of Amount of Program Reimbursement	B [omitted, see ¶20,703
III. *Program Instructions* § 2606, Part A Intermediary Manual, Part 2 (HIM-13-2)—Content of Notice of Amount of Program Reimbursement	C [omitted, see ¶13,510.64]
2. § 2202.7, PRM (HIM-15)—Special Care Units	D [omitted, see ¶6096

Contentions of the Parties
Provider

The providers contend that patients are often transferred to the DOU/IMCUs from the Intensive Care Units (ICU) or Coronary Care Units (CCU) 2 or 3 days ahead of time to make room for more acutely ill or postoperative patients. Also, patients are admitted directly from the Emergency Room to the DOU/IMCUs for acute care or observation which cannot be obtained in the general routine medical/surgical areas. The providers contend that in other hospitals these patients would be admitted to an intensive care unit or a coronary care unit. The providers assert that elimination of the multipurpose special care units (DOU/IMCUs) will increase Medicare costs by requiring greater utilization of the more costly intensive care units.

The providers contend that, although certain care rendered in the DOU/IMCUs is sometimes characterized as a "step-down" function, these units provide an extraordinary level of care to patients. The providers further contend that there is no requirement in the Regulations or *Manual* to support the Bureau of Health Insurance (BHI) [Medicare Bureau] position that nursing services in multipurpose special care units must be

at least equal to the nursing services provided in other special care units (i.e., ICU, CCU). The providers assert that BHI's position is unwarranted and ignores the fact that the multipurpose special care units were established to provide a level of care with relatively high-density nursing at a far lower cost than that provided in the specific-purpose intensive care units.

Criteria established in Regulation §405.452(d)(10) set forth that a special care unit (1) must be in a hospital; (2) must have extraordinary care provided on a concentrated and continuous basis; (3) must be physically identifiable as separate from general care areas; and (4) must have specific written policies for each designated unit.

The providers contend that the key in applying this Regulation is in the level of care. The providers assert that, in examining a level of care for special care units, the scope of services provided should not be limited solely to nursing activities or a comparison of nursing hours and costs with other special care units. Regulation §405.452(d)(10) speaks of "care," not "nursing care."

The providers contend that the routine care nursing salary differential recognizes that Medicare patients require a higher level of nursing care. The providers assert that the differential was never intended to be applied to Medicare patients that need extraordinary care provided in the special care units. Therefore, the costs, revenues, and patient days in the DOU/IMCUs should not be reclassified to the general routine category but should remain identified with a special care unit. The providers assert that denial of such costs would mean that non-Medicare patients would bear the costs of medically necessary services rendered to Medicare beneficiaries, contrary to Regulation §405.402(a).

The providers contend that the patients in the DOU/IMCUs need substantially more care than that which can be provided in the general routine

medical/surgical areas and that such care is medically necessary. Further, the providers contend the DOU/IMCU areas meet the requirements of the Regulations and the *Manual* for special care units. Therefore, the Intermediary's adjustments should be reversed.

Intermediary

The Intermediary contends that it was operating under two broad regulatory restraints. First, Medicare recognizes only two levels of care for reimbursement of hospital inpatient services—general routine care and special routine care. Second, routine per diem cost limits apply only to general routine care. Therefore, attention must be focused on special routine or special care units to make sure that they are properly excludable from routine care.

The Intermediary contends that the criteria used to determine program reimbursement for general routine or special care services are based upon (1) the amount of nursing care; (2) the level of nursing skills; and (3) the technical and facility resources utilized.

The Intermediary further contends that the definition of a Definitive Observation Unit/Intermediate Care Unit does not encompass the provisions of extraordinary care procedures, but rather refers to the provision of general routine medical/surgical care on a more frequent or continuous basis, as required by the needs of the individual patients.

In making its determination, the Intermediary reviewed the following areas:

1. Unit located in inpatient area of hospital and physically separate;
2. Availability of facility resources;
3. Ancillary services;
4. Staff/patient ratios;
5. Specific written policies for the unit;

6. Other related factors, such as

   A. Per diem charges for care rendered in the unit;

   B. Utilization and occupancy levels in the Unit—total and Medicare; and

   C. Average length of stay in the unit.

The Intermediary contends that, in its examination, some of the characteristics of the DOU/IMCUs met the criteria for a special care unit; however, others did not. The Intermediary asserts that the nursing salary costs and nursing hours per patient day are significantly lower in the DOU/IMCUs when compared to those in other special care units, i.e., ICU or CCU.

The Intermediary contends that Regulation §405.452(d)(10) recognizes a level of care above routine only where such care is extraordinary and on a concentrated and continuous basis. The Intermediary further contends that nursing care which does not meet this test—extraordinary and on a concentrated and continuous basis—is treated as routine care. The Intermediary asserts that Medicare makes no provision for recognition of intermediate levels of care except to the extent that including costs of intermediate care units in routine costs increases the average per diem.

The Intermediary contends that, in drafting the regulations, the criteria were established which a hospital inpatient unit must meet to be treated as a special care unit. However, certain hospital inpatient units which would qualify for treatment as a special care unit were also identified. These include, but are not limited to, the following units.

1. Burn
2. Coronary Care
3. Pulmonary Care

4. Trauma

5. Intensive Care

It is the Intermediary's position that, in identifying certain types of units in which the level of care would generally be "extraordinary and on a concentrated and continuous basis," those drafting the regulations intended to establish standards against which other units could be measured to determine whether the care rendered in such units was extraordinary, concentrated and continuous.

The Intermediary further contends that, if application of a number of simple tests i.e., a comparison with established special care units of nursing care hours per day or direct and total costs per day, reveals significant differences, one may reasonably conclude that the care in these units is not substantially the same as the care in other special care units. Therefore, such units would not qualify as special care areas.

The Intermediary asserts that its analysis of the providers' DOU/IMCU areas indicates that the care rendered is more intense than that found in the average routine unit, but not as intense as that found in the special care units. The Intermediary further asserts that:

1. The Medicare regulations do not recognize intermediate care units, such as the providers' DOU/IMCU areas, for program reimbursement; and

2. The DOU/IMCU areas were found to be less than special care units.

The Intermediary concludes that, based on the facts as stated above, its adjustments to include the costs and statistics of the providers' DOU/IMCU areas in the general routine area category were appropriate and should be upheld by the Board.

Conclusions and Findings

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, testimony elicited at the hearing, and post-hearing briefs submitted, concludes and finds that the Intermediary's adjustments should be reversed.

Although the providers' DOU/IMCUs are not exactly the same in each facility, the Board finds that all three of these multipurpose special care units qualify as special care inpatient hospital units for Medicare reimbursement purposes.

Testimony elicited at the hearing showed that a major reason the DOU/IMCUs were established was in an effort to reduce the high incidence of sudden death for those patients suffering from acute myocardial infractions and serious cardiac arrhythmias. The provider used a somewhat newer manner of treatment for patients that have suffered a heart attack. These patients are continually monitored from the time of hospital admission to the time of discharge. Testimony further showed that heart attack patients in the providers' facilities were generally sent to a CCU for 3 to 5 days, and then moved to a DOU/IMCU for another week to 10 days for ambulation. This type of patient requires telemetry monitoring and close observation and attention by the medical and nursing personnel during this ambulatory phase. A preponderance of evidence showed that the DOU/IMCUs were, for the most part, an extention of the CCUs. A majority of the patients were in a high risk category subject to arrhythmias—abnormal heart rhythms—which could result in sudden death. The care these patients required was extraordinary and on a concentrated and continuous basis.

Testimony also showed that the DOU/IMCUs were used as an overflow for the ICUs. In fact, Hospital B did not have a Medical Intensive Care Unit. Therefore, pa-

tients who would have been placed in an ICU in another hospital were put in this facility's DOU/IMCU.

The Board finds that many of the other patients in the DOU/IMCUs, that is patients other than those that were transferred from the CCUs and ICUs, had multi-system disorders that required substantially more medical care, supervision and monitoring than that available in the general inpatient routine care areas. Examples of some of these other types of patients in the DOU/IMCUs were ones that required peritoneal dialysis, intensive respiratory therapy and cancer patients that required chemotherapy.

The controlling Regulation, §405.452(d)(10), states that, to be considered a special care inpatient hospital unit, the unit must:

1. Be in a hospital;

2. Be one in which the care required is extraordinary, and on a concentrated and continuous basis;

3. Be physically identifiable as separate from general patient care areas; and

4. Have specific written policies.

The Regulation further states that such designated units include, but are not limited to, burn, coronary care, pulmonary care, trauma and intensive care units. However, the Regulation specifically excludes post-operative recovery rooms, post-anesthesia recovery rooms and maternity labor rooms from the special care category.

The Board finds that the *Manual,* which purports to interpret the Regulations, contained no further clarification of special care units until the publication of Revision No. 177, contained in §2202.7 [¶6096], HIM-15, dated June 1977. The Board notes that this revision was promulgated about the time of this Board hearing. In

that revision, BHI defined extraordinary care as incorporating extensive life-saving nursing services of the type that is generally associated with the services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. For this reason, special life saving equipment should be routinely available in the unit. The revision further states that the units' nursing personnel must not be integrated with the general care nursing personnel. Also, the units' staff must be specially trained to serve in the special care area.

Uncontroverted evidence presented to the Board showed that the providers' multipurpose units meet the criteria established in the Regulations for special care inpatient hospital units. It is unrefuted that the DOU/IMCUs are located within a hospital, have written policies, and are physically separate from the general inpatient routine areas. Evidence presented to the Board shows that these units are located adjacent to the CCUs and ICUs. The location of the DOU/IMCUs is important since specially trained nursing personnel with appropriate skills is available from the CCU or ICU for use in emergenices.

Nurses in the CCUs, ICUs, and DOU/IMCUs received the same type of training. These nurses received special training which was over and above the normal training for nurses in the general routine care areas. The floating nurse policy provided that nurses for the special care areas were interchangeable. That is, they could be used for either the CCUs, ICUs, or DOU/IMCUs. But general routine care nurses were not used in the special care areas (CCU, ICU, DOU/IMCUs), since they did not have the required special training.

The Board also finds that the care required in the DOU/IMCUs was extraordinary, and on a concentrated and continuous basis. Evidence presented at the hearing showed that, if the providers did not have a DOU/IMCU, most of the patients treated in these units would have to be treated in the CCU or ICU.

Evidence presented also showed that the DOU/IMCUs contained special services and equipment that were not available in the routine care areas on a normal basis. In Hospital B, the charge for services rendered to patients in the DOU/IMCUs is an all-inclusive charge, except for ancillary services received from outside the special care area. The charge structures in Hospitals A and C were similar. This all-inclusive rate, however, was substantially more than the amount charged in the general routine care areas. If patients in the routine areas needed additional ancillary or other services that were available, they were billed separately. Although some of the services rendered and equipment used in the DOU/IMCUs on a regular basis could be specially ordered for patients in the general routine areas, the intensive nursing services were available only in the special care areas: CCU, ICU and DOU/IMCU.

It appears that the Intermediary has tried to apply the criteria contained in Revision No. 177 to the instant case. The Intermediary contended the providers' DOU/IMCUs did not qualify as special care units because (1) they were referred to as a "step-down" unit or intermediate care unit, and (2) the nursing services provided in the units were less than that provided in an established special care unit. The Board finds that this *Manual* revision is the first time that BHI has enunciated this policy. The Board notes that the term used by BHI to define the DOU/IMCUs is not particularly relevant. One must go beyond the limits of a definition and make a full examination of the units themselves to determine whether they qualify as special care or general routine care units. Evidence presented to the Board conclusively showed that the care rendered in the providers' DOU/IMCUs was substantially above that which was rendered in the general routine care areas. Also, the Board notes that the staffing of the DOU/IMCUs was substantially greater than the staffing in the general routine care areas.

Further, the Board notes that there was no evidence that the staffing in the DOU/IMCUs was reduced on weekends. Generally, hospital stays of seriously ill patients, such as those with heart disorders or multi-system disorders, cannot be readily predicted so that they can be scheduled to go home by the weekend. Therefore, staffing patterns in special care units tends to be more constant than staffing for patients in the routine care areas. In the instant case, this was true for the Providers' CCUs, ICUs, and DOU/IMCUs.

The Board does not agree with that portion of Revision No. 177, §2202.7B [¶6096] of HIM-15, which states that, if the hours of nursing service per patient day are less than the hours of nursing services provided in an established special day care unit, such as an ICU or CCU, then the units in question would generally not qualify as special care units. The Board agrees with the providers' assertion that, in examining a level of care for special units, the scope of services provided should not be limited solely to nursing activities or a comparison of nursing hours and costs with other special care units. All special care units do not require the same medical services, i.e., nursing hours and equipment, etc. Some units require a nurse to patient ratio of 1:1 while others may require a 1:2 or 1:3 ratio. Therefore, a requirement that nursing hours be similar to the already established special care units is inappropriate. This does not provide the hospitals with any flexibility or incentive to keep costs down. On the contrary, it encourages waste and increases costs.

The Board also disagrees with the *Manual* example in §2202.7B [¶6096] HIM-15, which states that, when patients in the unit in question are generally transferred from a qualified special care unit (i.e., CCU, ICU) after their condition has improved, this would indicate that the intensity of care required is less than that needed to qualify for a special care unit. In the instant case, it has clearly been demonstrated that patients suffering from

acute myocardial infarctions and serious cardiac arrhythmias need to be continually monitored. Testimony elicited at the hearing also showed that the same holds true for patients with multi-disorders. It is more appropriate to have these types of patients, as well as other patients that require relatively high-density nursing and special equipment, treated in an area where a more cost effective utilization is attainable.

The Intermediary's witness stated that the providers' DOU/IMCUs must be judged on an economic basis rather than on a medical basis. The Board finds that it is inappropriate to judge a special care unit solely on an economic basis. Such a determination should also be judged on a medical basis. The Regulations bear this out, since they require that care rendered in special care units be extraordinary, and on a concentrated and continuous basis. The Board is of the opinion that this requires both a medical and an economic determination.

The Board finds that the providers' DOU/IMCUs are not subintensive care units, but special care units. The Board also emphasizes that the list of special care units contained in the regulations includes, but *is not limited to* burn, coronary care, pulmonary care, trauma, and intensive care units.

The Board believes that it is important to point out that hospitals, such as the three providers in the instant case, that have carved our DOU/IMCU special care units from the general routine care area, should have a lower average routine care per diem cost than hospitals that do not have such units. Therefore, if such hospitals are included in computing the routine cost limitations, it would lower the limits to disadvantage those hospitals that did not have such special care units.

In conclusion, the Board believes that the use of the words "extraordinary," "continuous," and "concentrated" in Regulation §405.452(d)(10) is intended to indicate a degree of care that is substantially different from that which can be accounted for by the ordinary

differences in illnesses and the treatment thereof. The evidence presented conclusively shows that the care rendered in the providers' DOU/IMCUs was substantially different from the care rendered in the general routine area. The Intermediary's adjustments are reversed.

The providers challenged the adequacy of the NPRs issued by the Intermediary, contending that the Intermediary did not explain the basis for disallowing the DOU/IMCUs as special care units, as required in Regulation §405.1803. The Board is aware that the NPRs issued by the Intermediary may not fully conform with the applicable regulations. However, the NPRs are procedurally sufficient for the Board to attach jurisdiction. The issuance of defective NPRs has not denied the providers their due process or a fair hearing before this administrative body. Although the NPRs were defective, the providers were made aware of the audit adjustments and rationale for the adjustments several times before this hearing. However, it does appear that the Intermediary's position shifted from time to time. Further, the Board directed the provider and the Intermediary, by a letter dated March 9, 1977, to fully discuss the matters in controversy in accordance with 20 CFR 405, Regulations No. 5, Subpart R, §405.1853 [recodified as 42 CFR §405.1853], which is, in effect, a discovery period. In addition, preparatory to this hearing, adequate notice was given to the parties of the issues to be placed before this Board in the form of position papers and a hearing notice. The Board, therefore, finds that the defective NPRs have not been prejudicial to the providers.

The providers also challenged the Board's determination that the jurisdictional amount of $50,000 or more must be satisfied by the group for each cost reporting period. The providers contend that there is no basis in the Regulations for the Board's determination that the jurisdictional amount must be satisfied for each cost reporting period on a group appeal. In a March 9, 1977

letter to the providers, the Board pointed out that the group must meet the jurisdictional amount for each cost reporting period, as required under 20 CFR 405, Regulations No. 5, Subpart R, §405.1837 and §405.1839(b) [recodified as 42 CFR §§405.1837 and 405.1839(b)]. However, since the issue in dispute did meet the jurisdictional amount for a group appeal, the Board accepted jurisdiction for both (2) cost reporting periods for Provider A and for one of the 2 years each for Providers B and C.

The providers requested that the Board reconsider its determination, pointing out that strict adherence to this interpretation could preclude almost all but identical fiscal year group appeals. On March 31, 1977, the Board sent a letter to the providers to inform them that it had considered their objections, but reaffirmed its position that the jurisdictional amount must be met by the group for each cost reporting period.

Decision

The providers' Definitive Observation Units/Intermediate Care Units qualify as "special care inpatient hospital units" for Medicare reimbursement purposes. The Intermediary's adjustments are reversed for the cost reporting years under appeal.

APPENDIX N

¶ 30,383 PRRB DECISION—CONCENTRATED CARE UNIT AS SPECIAL CARE UNIT—ADMITTING DEPARTMENT COSTS, INCLUSION IN A & G v. SEPARATE COST CENTER

PRRB Hearing Dec. No. 79-D98, Dec. 31, 1979 (cost reporting period ending May 31, 1977). *St. Luke's Hospital of Bethlehem (Bethlehem, Pa.) v. Blue Cross Assoc./Blue Cross of Lehigh Valley.*

Provider reimbursement—Determination of cost of services to beneficiaries—Special care units—Concentrated care unit.—A hospital's Concentrated Care Unit—a unit designed to handle seriously ill patients who required greater than normal nursing or medical care, i.e., heart attack victims, patients with acute respiratory failure, and patients with disbetic acidosis, and which was designed according to the "Special Care Units" section of the *JCAH Accreditation Manual for Hospitals*—was held to be a special care unit where it rendered care that met the requirement in Reg. §405.452(d)(10) that it be extraordinary and on a concentrated and continuous basis. Accordingly, an intermediary's reclassification of the costs, revenues, and patient days attributable to this unit to the general routine inpatient cost center was reversed. In so concluding, the Board noted that, while the nursing hours per patient day in the provider's ICU (21.9 hours) and in its CCU (13.5 hours) were in excess of the hours for the Concentrated Care Unit (8.4 hours), the hours for the unit in dispute were sufficiently in excess of the nursing hours per patient day in the provider's general routine care area (4.9 hours) as to indicate that an extraordinary intensity of nursing services was being rendered to patients in the Concentrated Care Unit on a concentrated and continuous basis. The significantly greater overall costs and charges per day between the ICU-CCU and the unit in dispute did not require a contrary decision,

inasmuch as various supplemental services in the Concentrated Care Unit were charged and costed as ancillary services, while the ICU and the CCU included comparable services in their appropriate charges and cost centers. *Back reference* ¶ 6096.

Provider reimbursement—Cost data and cost finding—Admitting department costs, inclusion in separate cost center v. inclusion in A & G.—Where a provider allocated its admitting costs to a separate Admitting Department Cost Center beginning in 1973, but in the 1977 fiscal year an intermediary refused to allow a separate allocation and included the admitting costs in the Administrative and General Cost Center on the ground that the provider had not received written approval to allocate admitting costs by means of a more sophisticated method, as required by Reg. §405.453(d)(2), the Board held that combining the admitting department's costs with administrative and general costs was improper and, thus, was reversed. The provider was held to have complied with the provisions in the *Provider Reimbursement Manual*—Sec. 231.1—which allow reclassification of the Administrative and General Cost Center into component cost centers. Thus, the provider had given adequate notice (as early as 1971) to the intermediary of its intention to establish a separate cost center for the admitting costs; and had demonstrated that it could establish only two subcomponent cost centers (admitting and other general service costs) because of accounting difficulties. In addition, the provider's intent in establishing a separate cost center was to properly assign these costs to the patients (inpatients) receiving the admitting services. *Back references* ¶[6475A,] 6480.14.

Issues

1. Whether the provider's treatment of its Concentrated Care Unit as a special care unit pursuant to Reg. §405.452(d)(10) is correct.

2. Whether the Intermediary's adjustment relating to the allocation of Admitting Department costs is correct.

Statement of Facts

St. Luke's Hospital of Bethlehem is a 449 bed short-term, acute care, non-profit hospital. For the May 31, 1977, reporting period, its rate of occupancy was 82.96% while its Medicare utilization rate was 34.67%. The Notice of Program Reimbursement (NPR) for the May 31, 1977, cost reporting period was issued on February 10, 1978. The provider timely filed its request for a hearing before the Provider Reimbursement Review Board on July 31, 1978.

Regarding the Concentrated Care Unit issue, in the early 1970's the Intensive Care Unit Committee of the provider's medical staff formulated plans for establishing a 25 bed Concentrated Care Unit to serve as a multi-purpose special care area. This unit was designed to handle seriously ill patients who require greater than usual nursing or medical care. It was designed according to the "Special Care Units" section of the *JCAH Accreditation Manual for Hospitals*. The provider treated this unit as a separate special care unit cost center on its cost reports. The Intermediary denied treatment of the Concentrated Care Unit as a special care unit because it did not meet the fourth requirement of Reg. §405.452(d)(10); that is, that the special care unit must

provide extraordinary care on a concentrated and continuous basis. This adjustment resulted in a reduction of Medicare reimbursement of approximately $30,000.

Regarding the Admitting Department's cost allocation, since 1973 the provider has allocated its admitting costs to a separate Admitting Department cost center. Beginning in FYE 1977, the Intermediary rejected this method and allocated admitting costs to the Administrative and General Cost Center. The provider maintains that this reallocation was improper since: (1) it results in a less accurate method of cost finding, and (2) the provider had permission to break out admitting costs from the Administrative and General Cost Center. The Intermediary contends that the provider did not receive written approval for allocating admitting costs on a more sophisticated method as required by Reg. §405.453(d)(2). Further, the provider did not comply with the written approval requirements of PRM Sec. 2313.1 [¶ 6475A] ff. This adjustment resulted in a reduction of approximately $5,000 in Medicare reimbursement.

Citations of Applicable Law, Regulations and Program Instructions

I. *Regulations*

1. §405.452(d)(10)—Definition of Special Care Units . . . [omitted, see ¶6025]

2. §405.402(b)(3)—Cost Reimbursement—General . . . [omitted, see ¶18,934]

II. *Program Instructions*

1. §2202.7—Special Care Units . . . [omitted, see §6096]

2. §2313.1—Alternative Allocation of Administrative and General Expenses . . . [omitted, see ¶6475A]

Contentions of the Parties

Provider

Issue No. 1

The Intermediary does not dispute that the provider's Concentrated Care Unit meets the first three criteria of Reg. §405.452(d)(10). The reimbursement dispute centers on the fourth criterion: whether the care in the Concentrated Care Unit is extraordinary and on a concentrated and continuous basis. The provider maintains that its Concentrated Care Unit meets this standard, and that the costs, revenues, and patient days in the Concentrated Care Unit should not be reclassified to the general routine category but should be included in a separate calculation of routine per diem costs for a special care unit (SCU).

In support of its contention that its Concentrated Care Unit meets the fourth condition above for a SCU, the provider would endeavor to show: (1) how the Regulation was intended to be construed, and (2) how the Regulation should properly be applied to a Concentrated Care Unit.

In order to determine whether the care rendered in a Concentrated Care Unit is "extraordinary and on a concentrated and continuous basis," it is necessary to determine the intended meaning of these words. This is done through the application of well-settled rules of statutory construction which are also applicable to regulatory interpretation. *See, E.G., M. Kraus & Bros., Inc. v. United States*, 327 U.S. 614, 66 S. Ct. 705 (1946). The meaning of "extraordinary and on a concentrated and continuous basis" is clear from the face of the Regulation. The intent of a regulation must be determined primarily from the language of the regulation. No intent may be imputed to the Secretary in the enactment of a

regulation other than such as is supported by the face of the regulation itself. Similarly, it is also a well-settled rule of statutory construction that words of a regulation will be interpreted in their ordinary meaning and significance, according to the meaning commonly attributed to them. It is also a well-settled rule of construction that dictionary definitions of words may be used as an aid in determining the scope or meaning of such words in a regulation or statute. A dictionary definition of "extraordinary" indicates that the term means going beyond what is usual, regular, and customary. Moreover, "extraordinary" does not have a special technical or legal meaning. Neither "extraordinary" nor "concentrated" nor "continuous" are defined anywhere in the Medicare regulations. Moreover, *Black's Law Dictionary* defines "extraordinary" simply as "out of the ordinary; exceeding the usual or average normal measure or degree; beyond or out of the common order; not usual, not regular, not customary." *Black's Law Dictionary* 699 (4th ed. 1951). "Extraordinary" is defined in *Webster's Dictionary* as "not in the usual, customary, or regular course; not ordinary; beyond or out of the common order or method." Similarly, the words "concentrated" and "continuous" have commonly understood meanings, are not used as legal terms of art, and should be construed as they are properly understood.

Regarding the application of Reg. §405.452(d)(10), the provider contends that the care rendered in a Concentrated Care Unit is extraordinary and on a concentrated and continuous basis. Such special care in a Concentrated Care Unit is demonstrated by: (1) the intensity of nursing care, (2) per diem operating costs, (3) the severity and nature of the illnesses of the patient in the Concentrated Care Unit, (4) the sophistication of the equipment, (5) facilities in the Concentrated Care Unit, and (6) the transfer of patients to and from the Concentrated Care Unit.

Regarding the *intensity of nursing care*, in making its determination that the Concentrated Care Unit did not meet the regulatory definition of a special care unit (SCU), the Intermediary took into consideration the staffing patterns of the nurses in the Concentrated Care Unit. The Intermediary noted that the level of nurse staffing in the Concentrated Care Unit is less than that found in ICU or CCU. In effect, the Intermediary appears to require that, before a unit may qualify as a SCU, it must have a nursing staff pattern equivalent to that found in an intensive care unit. However, "intensive" care is not an element required by the Regulation. Nor is "nursing care" the equivalent of "care" referred to in the Regulation. Although the intensity of nursing care in a Concentrated Care Unit is less than in ICU, the totality of care provided in a Concentrated Care Unit is extraordinary and on a concentrated and continuous basis, and that is the yardstick for the special care unit.

Many factors must be considered in determining whether care in a Concentrated Care Unit is extraordinary and delivered on a concentrated and continuous basis. The number of nursing hours per patient day is simply one item to be considered and certainly should not be dispositive of the issue. Such factors as the severity of the patients' illnesses, the level of training and specialization of the unit personnel, the types of nursing interventions necessary, the use of specialized equipment, and the frequency of necessary treatment and/or surveillance of the patients should be considered in determining whether the care rendered is extraordinary and on a concentrated and continuous basis.

In addition, the intensity of nursing care need not be equivalent among special care units. Standard II of the *JCAH Manual* states that:

> The staffing ratio of nurses to patients in special care units is often one nurse to two or three patients,

per eight-hour shift. Depending on the type of care required, however, the ratio may need to be increased to two nurses for every three patients, or even to one nurse for every patient.

Even though nurse hours in the Concentrated Care Unit are not as great as in ICU or CCU, they are still substantially greater than in routine. According to the provider's written *CCA Manual,* a Concentrated Care Unit provides a concentration of skilled personnel and equipment for monitoring, observing, and treating patients with various serious illnesses. Moreover, the level of care provided in the Concentrated Care Unit is significantly above that which is possible or practical in a general routine nursing unit. In fact, during fiscal year 1977, the intensity of nursing in the Concentrated Care Unit was nearly double that in the routine floors. Nurse hours per patient day in the Concentrated Care Unit (8.4) were 171% of those in routine (4.9), while nurse hours per patient day in CCU (13.5) were only 160% of those in the Concentrated Care Unit. Thus, even though the intensity of nursing care is only one factor of many to consider in determining whether the Concentrated Care Unit qualifies as a SCU, it must be stressed that nurse hours in the Concentrated Care Unit are substantially greater than those in routine. Accordingly, even from the singular standpoint of nurse hours, the Concentrated Care Unit should qualify as "extraordinary." This conclusion is only strengthened in view of the fact that Concentrated Care Unit nurses are specially trained and better paid than their routine ward counterparts. Thus, for one hour of nurse time, a Concentrated Care Unit patient gets better skilled and better paid nursing care than a routine patient.

Regarding the per diem operating costs, the costs to the provider of maintaining a Concentrated Care Unit, and the provider's charges to Concentrated Care Unit patients for the special care they receive therein, reflect

the extraordinary care rendered in the Concentrated Care Unit. Average cost per patient day in the Concentrated Care Unit greatly exceeded that on the routine floors. Similarly, the average total charge per day during fiscal year 1977 was substantially higher to Concentrated Care Unit patients.

The Intermediary argues that, unless costs for the Concentrated Care Unit are equivalent to those for ICU or CCU, the relative cost structure suggests that Concentrated Care Unit patients are *not* receiving special care. But this conclusion is unwarranted. Special care is "extraordinary" care. The cost structure here shows that the care rendered in this unit costs the provider substantially more per patient day than routine care. The cost of the Concentrated Care Unit care is above and beyond the cost of "routine" care. Thus, the cost differential *does* suggest that Concentrated Care Unit care is "extraordinary."

Regarding the nature and severity of illness, a patient is admitted to the Concentrated Care Unit when his illness is such that the Concentrated Care Unit can offer him the extraordinary, concentrated, and continuous care he requires more effectively and efficiently than any other hospital unit. For example, a person who has suffered a heart attack needs the extraordinary care of a nursing staff specifically trained to treat and recognize warning signs of ventricular fibrillation or other signs of heart failure. Although a routine floor nurse might be able to recognize an arrhythmia, she would be unable to provide the extraordinary care that a Concentrated Care Unit nurse, by virtue of her special education and experience, is able to administer to a patient with heart distress. The Concentrated Care Unit also treats patients with acute respiratory failure who require the care of specially trained personnel to operate the special equipment used in the Concentrated Care Unit. The Concentrated Care Unit also treats patients with the life-threat-

ening condition of diabetic acidosis. Such a patient has been described as requiring intensive nursing and physician care. These are a few examples of the types of seriously ill patients who have received extraordinary, concentrated, and continuous care in the Concentrated Care Unit.

Because of the seriousness of their illnesses, most, if not all, Concentrated Care Unit patients would be treated in ICU or CCU if the Concentrated Care Unit did not exist. This would result in inefficient use of ICU and CCU for the treatment of patients not requiring the totality of intensive care provided therein. To the extent that CCU and ICU could not accommodate all Concentrated Care Unit type patients, the incidence of death from cardiac arrests and other disorders would increase markedly without the special monitoring, staffing, and equipment found in the Concentrated Care Unit.

Regarding the sophisticated equipment in the Concentrated Care Unit, the use of equipment in Exhibit P-1 introduced at the hearing is generally restricted to concentrated care areas. If a patient from a routine ward requires treatment involving CCA equipment, that patient is generally transferred to the Concentrated Care Unit or another CCA for the necessary treatment. Utilization and maintenance of the Concentrated Care Unit equipment is strictly in accordance with Standard III of the Special Care Units Section of the 1970 *JCAH Manual* and its accompanying interpretation. Standard III provides that "[t]he design of, and equipment for, special care units shall facilitate the effective care of the patient.

It should be noted that the drafters of the Regulation borrowed heavily from the *JCAH Manual* Principle and Standards governing special care units in formulating a definition of special care units for Medicare reimbursement purposes. Accordingly, the Concentrated Care Unit's full compliance with Standard III audits interpre-

tation is further evidence that the Concentrated Care Unit meets the regulatory definition of a special care unit.

Regarding the transfers of patients, Concentrated Care Unit patients may come from routine floors, CCU or ICU, or directly from the emergency room depending upon the patient's needs. Similarly, a Concentrated Care Unit patient may be transferred to ICU, CCU, or general floors, depending upon the patient's condition. On rare occasions, a Concentrated Care Unit patient may even be discharged directly from the hospital. None of these admission or discharge patterns suggests that the care provided in the Concentrated Care Unit is not extraordinary or on a concentrated and continuous basis. In past cases, the Intermediary (or the Administrator) has inferred from patient admission or discharge patterns that the care in a "progressive" SCU amounted essentially to "routine nursing care rendered to a patient until he is well enough to go home." Simple transfer of a patient from one SCU to another as his condition improves does not raise a conclusive presumption either that: (1) the second unit does not provide extraordinary care on a concentrated and continuous basis; or (2) the transferred patient no longer needs such care.

Expert testimony at the hearing also brought out the following characteristics of the Concentrated Care Unit and other special care units:

1. Nursing service in the Coronary Care Unit (CCU), which has specifically been recognized as a special care unit under Medicare regulations, does not offer continuous and concentrated care at all times. There are times when patients are just being monitored and receive very little "on hands" nursing care.

2. The provider's ICU essentially offers intensive care for surgical patients, while the Concentrated Care Unit offers intensive care for the critically ill medical care patients.

3. The comparison of the provider's Concentrated Care Unit with the Intermediary's expert witness' Progressive Care Unit is inappropriate because:

a. Additional services such as ventilation therapy are offered in St. Luke's Concentrated Care Unit, whereas such services are offered in the ICU of the hospital of the Intermediary's witness.

b. Very few, if any discharges are made from the provider's Concentrated Care Unit. Patients are generally transferred to routine care areas before discharge. In the witness' hospital, patients are generally dismissed directly from the Progressive Care Unit.

The provider also contends that Sec. 2202.7 [¶6096] of the *Provider Reimbursement Manual* (HIM-15) cannot be applied because it is not supported by regulation, cannot be retroactively applied, nor was it properly promulgated.

Issue No. 2

The breakout of admitting costs from the Administrative and General (A&G) Cost Center conforms with general Medicare program policy and results in more accurate cost finding. In considering the issue of whether the provider properly segregated admitting costs from the A&G cost center, several important statutory and regulatory principles must be kept in mind. Congress, in enacting the Medicare legislation, required the Medicare program to reimburse providers for the "reasonable cost" of such services. 42 U.S.C.A. §1395f(b). The statute included the directive to the Secretary of Health, Edu-

cation and Welfare (HEW) that, in drawing up the Medicare regulations, he "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles)." 42 U.S.C.A. §1395x(v)(1)(A). This statute went on to set a basic Medicare reimbursement standard: "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs . . . will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs."

Besides these statutory principles, one regulation serves as a touchstone in this dispute. Reg. §405.453(d)(2)(ii) states:

> *More sophisticated methods*. A more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the intermediary. However, having elected to use the double-apportionment method, the provider may not thereafter use the step-down method without approval of the intermediary. . . . Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

This principle—that providers *may* use more sophisticated cost finding methods but that, once having begun to use those more sophistication methods, the provider must continue to do so (with a change towards either more or less sophistication having to be approved by the intermediary)—seems eminently logical.

Including admitting costs in the Administrative and General Cost Center is an unsophisticated and inaccurate method of allocating costs. In addition, admitting is not a general service cost center. It does not render services to the whole hospital. Thus, by its very charac-

ter, it is markedly different than the other costs grouped in the A&G cost center.

Segregating identifiable costs from the A&G cost center is a more accurate and sophisticated method and is consistent with generally accepted accounting principles. In addition, the American Hospital Association *Chart of Accounts for Hospitals,* which serves as an industry standard, in its 1966 edition listed the Admitting Department neither under the *Administrative* Services Division nor under the *General* Services Division. Instead, it was grouped with other more nearly similar departments under the Fiscal Services Division. This grouping indicates that, under generally accepted accounting principles, the Admitting Department should be separated out from the A&G cost center. Further, since this arrangement of accounts has been endorsed by a national organization, the Congressional directive must be kept in mind that in establishing regulations (and also, of course, *Manual* sections, and Medicare program forms) "the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations" 42 U.S.C.A. §1395x(v)(1)(A).

Returning these admitting costs to the A&G cost center would constitute a return to a less sophisticated method. Besides permitting a more sophisticated method to be used, the applicable regulatory and *Manual* sections prohibit a return to a less sophisticated method of accounting *unless* intermediary permission is requested and granted. In this case, no such request for a return to a less sophisticated method was made. By the fiscal year beginning June 1976 (the year in controversy), the provider had had its Admitting Department established (with Intermediary approval) as a cost center separate from A&G for four years. The provider was satisfied with this accounting method, and had no desire to change it. Nor did the Intermediary give permission for such a change; in fact, had such a request been made, it prob-

ably would have been denied. For example, one plan questioned BHI about "whether, under the provisions of PRM §2313.1, a provider must maintain the integrity of a component cost center if it exists." The provider in that case had a data processing system, but wanted to allocate data processing "along with its general and patient accounting cost centers rather than as a separate cost center." BHI replied that "the intent of Sec. 2313.1 was to create a uniform A&G allocation technique and that where a prescribed cost center is distinct and identifiable it must be allocated accordingly."

Thus, in reclassifying Admitting Department expenses to the A&G cost center, the Intermediary is contravening the express language of at least one regulation and three *Manual* sections besides §2313.1 (which also requires intermediary approval of accounting changes but which the Intermediary is using as the basis for requiring the reclassification.) Moreover, by requiring the provider to use a less sophisticated method, the Intermediary is forcing the provider to break the standard set forth in 42 U.S.C.A. §1395x(v)(1)(A): non-beneficiaries will be paying beneficiary Admitting costs.

The provider also contends that it complied with all four requirements of HIM-15 §2313.1. Requirement A is that the provider be using the Department Method of Cost Apportionment; the provider is doing so. Requirement B is that the provider must request permission to break out the cost center prior to the commencement of its cost reporting period; the provider made such a written request in May 1971. Requirement C first sets out the cost centers to be broken out and the allocation bases to be used, and then it provides further directions and information in a series of six subsections. Although the first subsection says that "providers must establish all six of these component cost centers or treat all administrative and general expenses as a single cost center," it also includes the provision "[e]xcept as provided below." The second subsection outlines the exceptions possible. The

provider in this case meets the exception contained in 2a: of the six component cost centers, only the Admitting Department satisfies the provisions of Requirement D because of physical organization problems. For example, data processing is spread over several areas within the hospital and is under the jurisdiction of different individuals: the pathologists control the laboratory hook-up to data processing while the Vice-President for Finance manages the remainder of the system. This physical and managerial organization makes the break-out of a distant Data Processing Department impossible. Similarly, such functions as telephones, purchasing, and patient accounting cannot be broken out of A&G. Therefore, according to §2313.1(C)(2)(a), only the Admitting Department need be broken out. The provider also meets the other provisions of Requirement C. For example, the Admitting Department *does* "include all costs normally includable in that cost center under generally accepted accounting principles."

The provider's Admitting Department in addition meets the provisions of Requirement D: The Admitting Department qualifies as a cost center under §2302.8 [¶6365], is separately identified in the provider's accounting system, has its costs recorded on a regular basis throughout the accounting period, and uses the statistical base required by §2313.1.

Regarding prior Intermediary approval of a change in cost centers, the provider contends that *the Intermediary had a duty to inform the provider if a re-request for permission was necessary*. The provider had already substantially complied with the requirement to request the permission of its intermediary to break out admitting costs. The provider had, in fact, given its Intermediary *over a year's notice* when it originally requested this permission. Moreover, the Intermediary had a duty—both a general and a specific one—to inform the provider if a re-request was necessary.

Finally, previous Provider Reimbursement Review Board (PRRB) decisions have recognized the validity of breaking out costs from the A&G cost center. The Board has dealt with cases involving the breakout of A&G costs many times in the past. Consequently, the Board has specifically recognized the principle that identifiable components of the A&G cost center can be allocated on bases other than accumulated costs provided certain conditions are met. For example, in *PRRB Decision* No. 75-D6, CCH MEDICARE AND MEDICAID GUIDE [1975 Transfer Binder] §27,497 [GUIDE ¶6475A.75], the Board found that:

> Although the Board recognizes that the substitute bases of allocating administrative and general expenses are allowable, in this instance the substitute bases did not produce a more accurate result.

In the case presently before the Board, however, none of the objections which the Board has raised in previous cases is applicable. The objection in the case cited above, for instance, was that the substitute base used did not result in more accurate cost finding. That, of course, is not the situation in this case—everyone, including BCA, agrees that segregating admitting costs out of the A&G cost center *does* result in more accurate cost finding. And, while the Board has in the past held that the base selected was improper, in this case the provider has used the base dictated by the Intermediary, (and the *Manual* section), even though the provider does not feel that base to be the most accurate one.

Intermediary

Issuer No. 1

The Intermediary contends that the Concentrated Care Unit in St. Luke's Hospital of Bethlehem, Pennsylvania, does not meet all the requirements necessary under the Regulations and Program policy to qualify it as a special care inpatient hospital unit. Reg. 42 CFR, Sec.

405.452(d)(10) and HIM-15, Part I, Sec. 2202.7 clearly state:

> To be considered a special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care required is *extraordinary* and on a *concentrated* and *continuous* basis and must be physically identifiable as separate from general patient care areas and there shall be specific written policies for each of such designated units. (Italics added for emphasis.)

Sec. 2202.7B of HIM-15, Part I, also states that some hospitals have units which provide more intensive care than that provided in the general care area yet not sufficiently intensive to permit the unit to meet the requirements to qualify as a special care unit under the definition provided in Paragraph 2202.7A of HIM-15, Part I. The provider claims that this unit qualifies as a special care unit by meeting all of the criteria contained in Reg. 42 CFR, Sec. 405.452(d)(10) and HIM-15, Part I, Sec. 2202.7ff. The Intermediary believes that the provider has not met the requirements which state, "The care required is *extraordinary* and on a *concentrated* and *continuous* basis." (Italics added for emphasis.) The Intermediary's contention is evidenced by the following:

> 1. Hours of nursing service per inpatient day in the Concentrated Care Unit vary considerably from the provider's already established Special Care Units, by 13.5 hours from the ICU and 5.1 hours from the CCU.
>
> 2. The inpatient cost per inpatient day in the Concentrated Care Unit is $112.06 as compared to the inpatient cost per day of ICU, CCU, and routine care of $246.15, $181.36, and $74.91, respectively. Relative to routine care, the inpatient cost per day for

the ICU is 228.59% greater, CCU is 142.10% greater, while the Concentrated Care Unit is only 49.59% greater.

3. The charge rate structure employed by the provider also indicates that the Concentrated Care Unit charge is a step above routine, and well below the special care unit charges in the ICU and in the CCU.

4. Comparisons among other provider's established special care units' hours of nursing service per inpatient day indicates that the Concentrated Care Unit of St. Luke's Hospital is a subintensive care unit per HIM-15, Part I, Sec. 2202.7ff.

The Intermediary also contends that the provider did not comply with Sec. 2202.7, HIM-15, Part I, which states: "Special life-saving equipment should be routinely available in the unit." This is evidenced by an equipment listing furnished the Intermediary on desk audit for each of the following units: Concentrated Care, Coronary Care, Intensive Care.

The rationale employed by the Intermediary for the disallowance of the Concentrated Care Unit at St. Luke's Hospital was identical for the fiscal year ended May 31, 1977, as for the fiscal year ended May 31, 1976, when the provider accepted the Audit Adjustment Report for the year ended May 31, 1976.

The Intermediary also introduced additional evidence in the form of expert testimony at the Hearing. The witness stated that he had visited St. Luke's Hospital for 45 minutes observing the operations of the provider's Concentrated Care Unit. He stated that the operation of his provider's Progressive Care Unit was similar in scope and responsibility to St. Luke's unit. His Progressive Care Unit was treated as a routine patient care area for Medicare reimbursement purposes.

Issue No. 2

The Intermediary contends that the provider did not receive written approval for allocating admitting costs on a more sophisticated method as required by 42 CFR 405.453(d)(2)(ii) and HIM-15, Part I, Sec. 2313. The Intermediary further contends that the provider did not properly employ the Program Instructions outlined in HIM-15, Part I, Sec. 2313.1ff. The provider's rationale for allocating admitting costs was included in a letter to the Intermediary dated December 21, 1977, as follows: "The Admitting Department has in the past years been allocated separately from the other administrative and general costs. This precedent was followed in fiscal 1977 for consistency. The Intermediary believes that this rationale does not justify the reclassification of admitting costs from Administration and General Expenses because of changes that occur in the Medicare Program from time to time, e.g., HIM-15, Part I, Sec. 2313.1. Additionally, the provider, in its filed 1973 Cost Report, reclassified admitting costs from Administration and General Expenses and allocated these costs to the Adults and Pediatrics Cost Center and the Nursery Cost Center. In 1976, the provider requested reopening of the filed 1973 Cost Report and, among other things, requested that the admitting costs previously allocated only to the Adults and Pediatrics Cost Center and Nursery Cost Center be allocated on the basis of gross inpatient revenues to all inpatient revenue-producing cost centers. This request was denied by the Intermediary in 1976 and was not appealed by the provider.

Additionally, the Intermediary contends that the provider has not complied with Sec. 2313.1 of the HIM-15. Sec. 2313.1 clearly states that a written request for approval must be submitted to the Intermediary and all of the component cost centers which a provider can establish must be established. The provider does not have the option to pick and choose what components it wishes to break out.

Also, the provider was notified as early as February 19, 1975, and twice in April 1976 as to the requirements for breaking out sub-cost centers within the Administrative and General Center including the requirements of written approval and identification of many sub-cost centers as the provider accounting system would permit.

Since the Plan did not make any adjustments until the cost report period ended May 31, 1977, the provider was given ample opportunity to comply with the provisions of Sec. 2313.1.

Conclusions and Findings

Issue No. 1

The Provider Reimbursement Review Board, after considering the facts, the parties' contentions, and evidence submitted, concludes and finds that the provider's Concentrated Care Unit is a special care unit as defined by Reg. §405.452(d)(10).

The primary issue in dispute is whether the Concentrated Care Unit offers concentrated and continuous care as required by the above regulation in order to be considered a special care unit for Medicare reimbursement. The Intermediary relied primarily on Program Instruction 2202.7.B, issued in June 1977, in classifying the provider's Concentrated Care Unit as a general routine care area. This section states that, if a unit of a hospital is not easily identified as a special care unit, a review of written policies of the various units will indicate whether a unit meets the requirements (unit in a hospital, extensive life-saving nursing services and equipment, separately identifiable, etc.) of Sec. 2202.7.A. It then offers two examples of when questionable units cannot *generally* be considered as special care units. They are: (1) where a unit has less hours of nursing service provided than in established ICU and CCU's,

and (2) where patients are generally transferred from a qualified special care unit after their condition has improved.

As evidenced from this Program instruction, extensive review of written procedures, and, in the Board's opinion, review of actual operations must be made in order to determine the appropriateness of a provider's treatment of a special care unit. The Program instruction provides only the above two examples to determine if a unit is a special care unit. However, since these are only examples, the Program instructions seem to indicate that other criteria may, and even should, be used in determining the treatment of a hospital's special care unit. In addition, the term "generally" stated in the two PRM Section examples provides hospitals with sufficient flexibility to establish varying types of special care units. Thus, by the use of only examples and "couching" types of terms such as "generally" in the PRM section, the Board concludes that unique factual circumstances can exist for hospital units that will result in their being considered special care units.

In this instant case, the provider's circumstances, both from a written policy and an actual operations standpoint, clearly demonstrates that its Concentrated Care Unit is a special care unit. The Intermediary's primary argument for comparing nursing hours per patient day for the special care units (21.9 hours for ICU, 13.5 hours for CCU and 8.4 hours for the Concentrated Care Unit) is inadequate and inconclusive. It only used one example stated in the *Provider Reimbursement Manual* in determining whether a unit is a special care unit or a subintensive care unit. Another major consideration in determining extraordinary nursing care on a concentrated and continuous basis is the comparison between the general routine nursing hours per patient day (4.9 hours in this provider) and the various special care units. In the Board's opinion, the provider's Concentrated Care Unit hours per patient day (8.4 hours)

significantly exceed the general routine care hours per patient day. This excess clearly indicates that an extraordinary intensity of nursing services are being offered to patients in the Concentrated Care Unit on a concentrated and continuous basis.

Regarding the Intermediary's comparison of special care unit statistics, the Board does note that a significant variance does exist between the nursing hours per patient day for each of the three special care units. However, this variance, in itself, is not conclusive that services in the lowest unit (Concentrated Care Unit) are not extraordinary and offered on a concentrated and continuous basis. The Board concludes that this variance results from the provider's efficient stratification of patients by type of illness within each special care unit. The ICU services surgical patients who require an extremely high degree of nursing care (almost one nurse per patient day). The CCU services patients who have severe cardiac disorders who require a high degree of nursing care but less care than surgical patients (one nurse per two patient days). The Concentrated Care Unit services patients with severe medical disorders who require a high degree of nursing care (one nurse per three patient days). However, in all three units, the nursing services per patient day significantly exceed the general routine nursing hours.

In cases where patients are stratified by the above specialties, it is difficult to use overall nursing unit averages of "established" ICU's and CCU's as bases for comparing and establishing other special care units. The very nature of stratifying patients and servicing them separately by illness type tends to distort averages and makes comparisons meaningless. This appears to be the reason why PRM Sec. 2202.7.B only offers examples for determining if a unit is a special care or subintensive care unit. The section appears to leave sufficient flexibility for exceptions to the special care unit comparisons which will allow special care treatment for units that

have lower per patient day statistics than the universally accepted ICU's and CCU's. The Board believes that this provider's stratification process of patients by illness, while still maintaining significantly greater nursing care than general routine care, results in special care unit treatment for the provider's Concentrated Care Unit.

Besides the nursing hours comparison, the Board concludes that the Intermediary's other arguments are inadequate to deny special care treatment of the Concentrated Care Unit. The Board notes that the Intermediary determined significantly greater overall costs and charges per day between the ICU-CCU and the Concentrated Care Unit. However, this argument is adequately rebutted by the provider who pointed out that various supplemental services in the Concentrated Care Unit were charged and costed as ancillary services, while the ICU and CCU included comparable services in their appropriate charges and cost centers.

In addition, the expert testimony offered by the Intermediary's witness demonstrated that the provider's Concentrated Care Unit and the expert witness' progressive care unit operated differently both as to the types of services rendered and the type of admissions made by the witness' hospital. Thus, the Board concludes that the Intermediary's comparison of units and resulting cost treatment is invalid and inadequate.

Issue No. 2

The Provider Reimbursement Review Board, after considering the facts, the parties' contentions, and evidence presented, concludes and finds that the Intermediary's adjustment combining the Admitting Department's costs with general and administrative costs is improper and, thus, is reversed. The provider has adequately documented that it complied with the requirements of PRM Sec. 2313.1. It had provided adequate notice (as far back as 1971) to the Intermediary of its intention to establish a separate cost center for the allocation of admitting costs. It also demonstrated from

its position paper and testimony presented that it could establish only the two subcomponent cost centers (admitting and other general service costs) because of accounting difficulties encountered in establishing separate cost centers for data processing, purchasing, and cashiering/accounts receivable. The provider clearly demonstrated that its intent to separately allocate admitting costs was to properly assign these costs to the patients (inpatients) receiving the admitting services. There is no indication that the provider was "picking and choosing" administrative costs in order to maximize its reimbursement. Thus, the separate allocation of admitting costs conforms with Regulation §405.402(b)(3), in that it results in a division of allowable costs between the beneficiaries of the Medicare program and other costs based on the actual use of services.

Decision

Issue No. 1

The provider's Concentrated Care Unit qualifies as a special care unit as defined in Reg. §405.452(d)(10). The Intermediary's adjustment is reversed.

Issue No. 2

The provider's allocation of Admitting Department costs separate and distinct from administrative and general expenses is correct. The Intermediary's adjustment is reversed.

APPENDIX O

¶ 28,745 STANDARD FOR JUDICIAL REVIEW OF PRRB DECISIONS—REHABILITATION UNIT AS SPECIAL CARE UNIT

Rolling Hill Hospital, Inc. v. PRRB, et al. Report and Recommendation of SCUDERT, U. S. Magistrate, adopted by U. S. District Court, Eastern District of Pennsylvania. No. 76-1878, Nov. 10, 1977. MCGLYNN, District Judge.

Notices, determinations, and appeals—Substantial evidence and scope of judicial review.—Since a PRRB decision is being reviewed by a court on the basis of the record made at the administrative hearing provided for and required by statute, the appropriate standard for judicial review is a determination of whether or not the findings of the Board were supported by substantial evidence. *Back reference* ¶ 13,540.58.

Provider reimbursement—Determination of cost of services to beneficiaries—Special care units—Rehabilitation unit.—A PRRB decision holding that a hospital's rehabilitation unit did not qualify as a special care unit under Regulation § 405.452(d)(10) was not supported by substantial evidence on the record as a whole, and, therefore, was not affirmed. In holding that the care provided in the rehabilitation unit satisfied the requirement in the regulation that it be "extraordinary and on a concentrated and continuous basis," the Court noted (1) the testimony of the provider's three key medical witnesses who sought to demonstrate the extraordinary, concentrated, and continuous nature of the care provided in the rehabilitation unit; and (2) the factors relied on by the intermediary and the Board in holding that the unit did not qualify as a special care unit—the intensity of nursing care, the per diem operating cost of intensive care units, and the severity of illness—were criteria not called for in the regulation. Accordingly, the hospital by a preponderance of the evidence established

that its rehabilitation unit qualified as a special care unit and was entitled to the cost reimbursement allowed for such units. *Back reference* ¶ 6096.

PRRB Dec., No. 76-D15, 1976 Transfer Binder ¶ 27,806, is reversed.

[Text of Magistrate's Opinion]

Report and Recommendation

This action arises under § 1878(f) of the Social Security Act, as amended 42 U. S. C. 1395oo(f) and under 5 U. S. C. 701 *et seq.* Plaintiff Hospital, as a Medicare provider seeks judicial review of a final decision of the Provider Reimbursement Review Board denying plaintiff the right to treat its Rehabilitation Unit as a special care inpatient hospital unit for purposes of Medicare reimbursement.

The case is now before the Court on cross-motions for summary judgment. Defendant, in the alternative, has moved to dismiss.

Background

Under the federal Medicare program established pursuant to § 1866 of the Social Security Act, as amended 42 U. S. C. 1395 *et seq.*, approved providers of hospital services are reimbursed by the government for certain costs attributable to the treatment and care of hospital patients who are eligible Medicare beneficiaries. To determine hospital costs of furnishing such services, the provider is required to file annual cost reports. 20 C. F. R.[now 42] 405.406.

The program recognizes that a hospital's costs are greater for treatment in special care units than in non-special care units, and, accordingly, establishes separate methods of calculating costs in each kind of unit.

To determine the reimbursable costs attributable to patient-beneficiaries treated in a non-special care unit of the hospital, the average daily cost for routine patient

services is calculated. The total allowable inpatient cost for routine services is divided by the total number of inpatient days of care rendered during the accounting period. 20 C. F. R. [now 42] 405.452(d)(7). To determine the reimbursable costs attributable to patient-beneficiaries in "special care" units, the average daily cost for routine services is also calculated. The final calculation, however, is computed by dividing the total allowable inpatient cost for routine services by the total number of inpatient days of care rendered only in the particular special care unit under consideration. 20 C. F. R. [now 42] 405.452(d)(8). The result is higher payments to providers for patient-beneficiaries treated in special care units reflecting the increased costs attributable to the operation of such a unit.

In order to administer the Medicare program, Congress authorized the Secretary of Health, Education and Welfare to enter into agreements with private organizations, referred to as Intermediaries, who have the duty of determining the payments which must be made to providers of health care services rendered to beneficiaries. 42 U. S. C. 1395(h).

Section 1878 of the Social Security Act, as amended, 42 U. S. C. 1395oo(a) provides for the establishment of the Provider Reimbursement Review Board (hereinafter "PRRB" or "the Board"). This is an appeals board empowered to hear and determine appeals from Medicare providers who are dissatisfied with the determinations made by the provider's fiscal intermediary on cost reports submitted by the provider and on amounts due the provider for services to Medicare beneficiaries.

The Secretary of HEW has delegated the responsibility for administering the Act to the Commissioner of Social Security. As the Secretary's delegate, the Commissioner is empowered to review decisions of the PRRB, pursuant to § 1878(f) of the Act, as amended, 42 U. S. C. 1395oo(f).

Facts

Plaintiff Rolling Hill Hospital, Inc. is a 330 bed short-term general hospital duly incorporated, organized and existing under the laws of the Commonwealth of Pennsylvania. Its principal place of business is located at 60 East Township Line, Elkins Park, Pennsylvania. The hospital is a provider of health care services under the federal Medicare program.

Defendants are the Provider Reimbursement Review Board (PRRB) and the Chairman and other members of the PRRB, each being sued in his official capacity.

Plaintiff operates and maintains a Rehabilitation Unit composed of 24 inpatient rehabilitation beds. The Rehabilitation Unit provides health care services for disabled or handicapped individuals whose physical impairment is a major component of their disorder and strives to treat these individuals so that they may regain the maximum possible function and lead lives as near to normal as possible.

Pursuant to the regulations and requirements of the Medicare program, plaintiff filed its cost report for the fiscal year ending September 30, 1973 with its Medicare Intermediary, the Blue Cross of Greater Philadelphia, a subcontractor for the Blue Cross Association, hereinafter, "Intermediary". In its cost report, plaintiff treated the Rehabilitation Unit as a special care inpatient hospital unit and computed a separate average per diem cost for the unit. (Tr. 15-44).

The Intermediary audited plaintiff's cost report and issued a Notice of Program Reimbursement to the Hospital for the cost reporting period ending September 30, 1973. In this notice, dated January 17, 1975, the Intermediary denied treatment of the Rehabilitation Unit as a special care unit. (Tr. 349-351).

Plaintiff requested a hearing before the PRRB which was held on February 26, 1976. (Tr. 46-249). On April

14, 1976 the PRRB issued a Hearing Decision denying plaintiff the right to treat its Rehabilitation Unit as a special care inpatient hospital unit and as a separate care cost center. (Tr. 3-13).

The Board's decision became final when the Commissioner of Social Security declined to reverse, affirm or modify the decision entered by the PRRB. (Tr. 1, 2).

Plaintiff then filed the present appeal against the PRRB and its members. Defendant asserted that, since the Secretary is the only proper party defendant, and since he had not reviewed the decision of the Board, the court lacked subject matter jurisdiction. Defendants' motion to dismiss the PRRB and the individually named members as defendants was denied, based on the fact that 42 U. S. C. 1395oo(f) explicitly provides for judicial review of the final decision of the PRRB. Plaintiff, conceding that the Secretary is a proper party to such a suit, filed an amended complaint adding the Secretary as a defendant. The relief sought includes a declaratory judgment and an order of reimbursement based on consideration of the Rehabilitation Unit as a separate special care cost center.

Issues

20 [now 42] C. F. R. 405.452 provides for apportionment of the cost of care rendered to a patient eligible for benefits under the Medicare program. 20 [now 42] C. F. R. 405.452(d)(10) provides for the apportionment of the costs of special care inpatient units to Medicare beneficiaries. The plaintiff treated its Rehabilitation Unit as a special care inpatient hospital unit pursuant to 20 [now 42] C. F. R. 405.452(d)(10) and sought reimbursement for the cost of operating the unit. That section, which is the basis for this appeal, states:

> Intensive care units, coronary care units, and other special care inpatient hospital units. To be considered an intensive care unit, coronary care

unit, or other special care inpatient unit, the unit must be in a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general patient areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units but exclude post operative recovery rooms, post-anesthesia recovery rooms, or maternity labor rooms.

The primary issue confronting the Board was whether or not plaintiff's Rehabilitation Unit qualified as a special care unit as defined in 20 [now 42] C. F. R. 405.452(d)(10).

Pursuant to 42 U. S. C. 1395oo(f), judicial review of PRRB decisions is to be made in a federal district court "pursuant to the applicable provisions under chapter 7 of Title 5 . . ." Section 706 of that Title defines the scope of review of agency action.[1] Since the present case is

1. § 706 Scope of review.

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

being reviewed on the record of an administrative agency hearing provided and required by statute, the appropriate standard of review is a determination of whether or not the findings of the agency are supported by substantial evidence. *Camp v. Pitts*, 411 U. S. 138 (1973); *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971).[2]

The accepted definition of substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U. S. 389, 401 (1971). "It consists of more than a scintilla of evidence but may be somewhat less

---

NOTES *(Continued)*

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court. In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party and due account shall be taken of the rule of prejudicial error.

2. In *Overton Park*, the Supreme Court confronted the issue of the scope of review applicable to an action by the Secretary of Transportation. Three alternative standards of judicial review derived from § 706 were discussed. Agency action found to be arbitrary, capricious, an abuse of discretion, not in accordance with the law or found to fail to meet statutory, procedural, or constitutional requirements must be set aside by the reviewing court. Such a standard of review is a narrow one, yet it requires that agency actions described in § 706(2)(A), (B), (C), (D) be set aside where the court finds them. The "substantial evidence" standard of § 706(2)(E) is authorized only when the agency action is based on the record of a hearing, whether the agency is rulemaking or adjudicating. Finally, *de novo* review, which entails a retrial of factual issues, is authorized by § 706(2)(F) only where agency adjudication resulted in faulty factfinding procedure, or where, in nonadjudicatory action, issues that were not before the agency are raised in a proceeding to enforce such action. 401 U. S. at 413-416.

Camp v. Pitts affirmed the *Overton Park* interpretation of the Administrative Procedure Act's standards of judicial review and, at 411 U. S. 141, reemphasized that the substantial evidence standard is appropriate when reviewing findings on a record.

Based on the Supreme Court's interpretation of § 706, therefore, the appropriate scope of review of the PRRB's decision in the current case is the "substantial evidence" test.

than a 'preponderance'/ of the evidence." *Ginsburg v. Richardson,* 436 F. 2d 1146, 1148 (3d Cir. 1971); *Litwak v. Secretary of Health, Education and Welfare,* 430 F. Supp. 586 (E. D. Pa. 1977).

The only issue before this Court, therefore, is whether there is substantial evidence upon the record as a whole to support the determination of the PRRB that plaintiff's Rehabilitation limit does not qualify as a special care unit.

Discussion

The Provider Reimbursement Review Board agreed that the regulations identified six separate criteria necessary for a special care unit:

1. The unit must be in a hospital

2. The patient care in the unit must be extraordinary

3. The care in the unit must be concentrated

4. The care in the unit must be continuous

5. The unit must be physically identifiable as separate from general patient care areas; and,

6. The unit must have specific written policies.

There is no disagreement in the record that the Rehabilitation Unit is located in a separate area of the hospital with its own entrance to the building and has specific written policies. (Tr. 68-69, 100, 121, 224-246, 385-425.) The disagreement centers on the nature of care provided in the Unit. Plaintiff Hospital contends that the patient care in its Rehabilitation Unit is extraordinary, concentrated, and continuous. Defendant disagrees.

[Hospital's Witnesses]

Plaintiff's case before the Board consisted of the testimony of five witnesses, three of them key medical

witnesses, whose objective was to demonstrate that the care afforded patients in Rolling Hill's Rehabilitation Unit is, in the commmonly understood sense of the words, "extraordinary", "concentrated", and "continuous".

Plaintiff's first witness, Richard Actman, is the Administrative Coordinator of the Rehabilitation Unit and a licensed physical therapist. (Tr. 65-85.) Mr. Actman first recommended to the Hospital that it develop such a unit, and he helped in its organization. He noted the policy manual which was developed for the Unit. Mr. Actman described the Unit as a multi-disciplinary team approach to paitent area, utilizing and coordinating the skills of psychiatry, psychology, physical, occupational and speech therapy, nursing, and the social services. He characterized such care as extraordinary and concentrated. The witness described the special physical facilities of the Unit adapted for the use of handicapped patients. The types of patients admitted include paraplegics, quadriplegics, arthritic, amputees, and pulmonary patients (with emphysema or bronchitis). (Tr. 74.)

Mr. Actman described the services included in daily charges to be room, board, nurses, social services, special rounds, conferences, family counseling, and informal patient contact by the therapists. Separate charges are made for physical, occupational and speech therapy and psychotherapy. (Tr. 77-79.)

The witnesses also explained the continuity of care deemed essential to the success of the Rehabilitation Unit. He testified to the coordination or care among the nursing staff shifts, aimed at insuring that the skills patients acquire in therapy are continually reinforced. He explained the communications system established through the medium of a bulletin board at each patient's bedside to keep the entire staff informed of the patient's progress and level of achievement and to prevent backsliding. (Tr. 82-83.)

Plaintiff's second witness, Dr. Arthur Silverman, is a practicing physician and Medical Director of the Rehabilitation Unit. (Tr. 85-106.) Dr. Silverman's testimony, including a slide presentation, sought to demonstrate the extraordinary, concentrated and continuous care provided in the Unit. He emphasized the importance of the close and constant patient contact and patient monitoring by all members of the staff. He described the careful communications system established through weekly conferences and the bulletin boards. (Tr. 87-89.) Dr. Silverman attested to the heightened nursing care required on the Unit. The nursing staff continuously assists patients in taking care of their own needs (grooming, eating, moving about) and works with visiting family members to instruct them in ways to help the patient. (Tr. 89-91, 103-105)—services which the hospital would generally not be able to provide.

The witness described the concentrated level of therapy. (Tr. 92, 101.) Most patients in the Rehabilitation Unit attend therapy sessions twice a day five days a week and once on Saturday morning, each session lasting two or three hours. The work of the speech therapist, pulmonary therapist, physical therapist, occupational therapist and full-time psychologist thus appear to provide a level of care unavailable in the rest of the hospital, where a 45-minute therapy session might be provided after which the patient is returned to his room. (Tr. 92.)

Expert witness Dr. Rodney Chronister, a physician, assistant professor rehabilitative medicine at Temple University, and Acting Director of the Rehabilitation Unit at Temple Hospital, testified that he was familiar with Rolling Hill's Rehabilitation Unit and with the Medicare Regulations. (Tr. 118-120.) In his opinion, the plaintiff's Rehabilitation Unit satisfies the criteria set down in the regulation defining "special care unit." (Tr. 121.)

Dr. Chronister explained that any speech, physical, and occupational therapy on the general medical-surgical unit was very episodic and subordinate to the medical-surgical problem for which the patient was admitted. If a patient is in the Rehabilitation Unit, he testified, the intensity and frequency of therapy is extraordinarily increased. All aspects of the patient's care are subordinated to the dysfunction and the training the patient needs to become independent. The witness noted the integration of the nursing staff into the rehabilitation team and the constant communication between therapists and nurses to monitor patient progress. He also testified to the concentration of care on specific goals. (Tr. 122, 131.)

Dr. Chronister attested to the continuity of care, characterized by the integration of therapy with floor care and communication in meetings, conferences, rounds, and informal contact. Further, the greater-than-traditional nurses' role was noted. (Tr. 123.) He agreed that the slackening of therapeutic activity overnight and on weekends was therapeutic in itself and noted the communication among the nursing shifts regarding what functional demands should be made of the patients. He emphasized the importance of the patient's active participation in the care. (Tr. 126-127.)

[Intermediary's Witnesses]

The Intermediary's case before the Board consisted of the testimony of two non-medical witnesses.

Eugene Ott, Director of Provider Reimbursement for Blue Cross of Philadelphia, testified to the in-house desk review made of plaintiff's Medicare cost reports. (Tr. 140-142.) Blue Cross hired accounting firm of Heffler and Company to audit the cost reports. John Baetzel, the Intermediary's second witness, is a certified public ac-

countant and a partner with Heffler and Company. It was he who was in charge of auditing the September 30, 1973 cost report of the Hospital. (Tr. 162-170.)

Both Mr. Ott and Mr. Baetzel testified that upon visiting Rolling Hill's Rehabilitation Unit, Heffler's initial determination was that the Unit was indeed a special care unit. Thereafter, the Intermediary called the auditor in to speak with him about the implications of the regulation and the requirements of "extraordinary", "continuous" and "concentrated" care. Mr. Baetzel was instructed by Mr. Ott to review the Unit again. After a second look, Mr. Baetzel concluded that the Unit was not a special care inpatient hospital unit. (Tr. 143-145, 162-164.)

The Intermediary did not contradict the Hospital's witnesses' factual descriptions of the activities of the Rehabilitation Unit. Indeed it could not, for Mr. Ott had never observed the Unit, and Mr. Baetzel admitted that he was not qualified to judge the nature of care provided in the Unit. (Tr. 167.)

Instead, the Intermediary and defendants in this suit contest the characterization of the care afforded as "extraordinary, continuous, and concentrated." In cross-examination of the Hospital's witnesses at the hearing, the Intermediary focused on three elements: the intensity of nursing care, the per diem operating cost of hospital units, and the severity of illness.

In making its determination that the Rehabilitation Unit at Rolling Hill Hospital did not meet the definition of the regulation, the Intermediary took into consideration the staffing patterns of the nurses in the Unit. It was noted that the level of staffing changes from shift to shift and that the intensity of nursing care falls on evenings

and on weekends. This was compared to the constant staffing level maintained and the 24-hour "on call" care afforded in an intensive care unit. (Tr. 145, 146).

In effect, the Intermediary indicates that a special care unit must be an intensive care unit. However, "intensive" care is not an element required by 20 [now 42] C. F. R. 405.452 (d)(10). Nor is "nursing care" the equivalent of "care" referred to in the regulation. Plaintiff's medical witnesses provided substantial evidence that the totality of care provided in the Rehabilitation Unit is of an extraordinary, continuous, and concentrated nature. Clearly defendants would not contend that rehabilitation therapy should continue unabated on the 11:00 P.M. to 7:00 A.M. shift.

The Intermediary also took into consideration the comparative cost of nursing services provided in the Rehabilitation Unit with the cost of nursing care provided by special care units already qualifying under the regulation. It was found that the cost of nursing care at Rolling Hill for routine nursing care was $16.50 per day and that the nursing care provided in the Rehabilitation Unit was $25.62 per day. No surcharge was imposed by the Unit for the special care area itself. The charge for the Hospital's intensive care unit nursing services was $59.85 per day. (Tr. 145, 311). Defendant argues that the statistical comparison reveals the degree of care being rendered in the intensive care unit and the rehabilitation unit is markedly different.

Although this is certainly true, it is also true that the degree of care being rendered in the Rehabilitation Unit and that being rendered in the routine medical-surgical unit is markedly different.

Further, the regulation does not require that care in special units be costly or that a special charge be made for a unit to be qualified as a special care unit. Section 405.452(e) states the objective of the law to be that the costs with respect to individuals covered by Medicare not be borne by individuals not so covered and that costs

with respect to non-beneficiaries not be borne by the program. Thus, if beneficiaries receive more than the average amount of services, the providers receive reimbursement greater than the average cost for all patients. Clearly, the services provided in the Rehabilitation Unit are different and *more* costly than those services rendered in the routine portions of the hospital. And "routine care" in the Unit, though it entails no surcharge, includes continuous nursing and informal care by therapists as well as special facilities.

Finally, the Intermediary argued that Congress intended that the special care units house critcially ill patients. The contention is that the special care unit concentrates on life-saving endeavors, whereas the Rehabilitation Unit does not deal in life-threatening situations. (Tr. 147).

Plaintiff's witnesses insist that the services rendered by the unit are life-supportive and in many cases life-saving. Further, the regulation does *not* require [that] special care units deal in life or death situations.

The Intermediary thus seems to be applying extra criteria in determining that Rolling Hill's Rehabilitation Unit is not a special care unit. Such a course is unjustified by the law.

Since Congress did not consider the language in the regulation promulgated by the Secretary and here in issue, we do not have the aid of legislative history. The regulation itself is all we have to go by. The six elements, and only those elements, are those which the law and the regulations require in order for the Unit to be considered a special care inpatient hospital unit. The regulation does not attempt to describe all the types of special care units that would qualify.

Yet, for the defendants, the main reason Rolling Hill's Rehabilitation Unit should not be classified as a special care unit is that the Unit does not give the intensive-type nursing care they believe the legislators

envisioned in initiating separate reimbursement for special care areas.

[*PRRB's Decision*]

In its decision (Tr. 8-13), the Board appears to have accepted the Intermediary's interpretative gloss on 20 [now 42] C. F. R. 405.452(d)(10) and failed to weigh the evidence before it in light of the language of that regulation.

The heart of the Board's decision reads as follows:

> (T)o qualify as a separate cost center, the differences must be more than those which ordinarily distinguish the care given to one type of illness or one type of patient from that given to another. Medicare reimbursement policies, for example, do not contemplate separate cost centers for orthopedic cases, pediatric cases, psychiatric cases, surgical cases, gynecological cares, etc. A Rehabilitation Unit is more analogous to a distinct part long-term unit than to an intensive care unit in a general hospital . . .
>
> Medicare reimbursement policies do contemplate separate cost centers for intensive care units, coronary care units, pulmonary care units, and burn units. Each of these involved a degree of difference from routine care which constitutes a difference in kind. In the case of this provider, the per diem nursing salaries in the intensive care unit were $59, almost four times that in routine care areas.
>
> The Board believes that the use of the words "extraordinary" "continuous", and "concentrated" in Regulation 405.452(d)(10) is intended to indicate a degree of care substantially different from that which can be accounted for by the ordinary differences in illness and the treatment of such illnesses. The

examples given . . . meet these criteria, but a rehabilitation unit does not. (Tr. 12-13)

It is questionable whether the Board gave reasoned consideration to all the material facts and issues. The Board does not discuss its conclusions in terms of the special characteristics of plaintiff's Rehabilitation Unit.

A careful examination of the record in this case reveals that plaintiff has by a preponderance of the evidence established that its Rehabilitation Unit renders care that is extraordinary, concentrated, and continuous and thus qualifies as a special care unit under 20 [now 42] C. F. R. 405.452(d)(10) entitled to the cost reimbursement allowed special care units.

The PRRB's decision that the Unit does not so qualify is not supported by substantial evidence based on the record as a whole. That decision cannot, therefore, be affirmed.

Wherefore, this United States Magistrate makes the following:

Recommendation

NOW, this day of October, 1977, IT IS RESPECTFULLY RECOMMENDED that the Defendant's motions for summary judgment and to dismiss be Denied, and that the Plaintiff's motion for summary judgment be Granted.